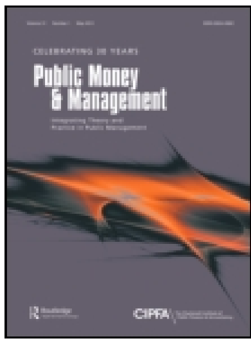

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NHS boards: knowing the 'what' but not the 'how'

Gianluca Veronesi and Kevin Keasey

Boards of directors play an increasingly fundamental role in British NHS trusts as well as other parts of the public sector. This study shows that their effectiveness is compromised by issues related to internal dynamics, processes, responsibility, overall functions and performance. The focus of governance, therefore, needs to shift from structural concerns to the multiple collective aspects of a board's behaviour.

The UK National Health Service (NHS) is a complex entity, employing around 1.5 million people and with a budget of more than £90 billion, where health care is commissioned and/or provided by autonomous organizations, trusts, under the supervision of the Department of Health. It is characterized by a multiplicity of objectives (such as individual patient care, overall population health and operational and financial control) and the stakeholders (end users, local communities, employees, politicians etc.) involved (Allen, 2006). These, coupled with the pace of change of the past 20 years, have contributed to a range of views on the characteristics of the system (Greener and Powell, 2008).

Traditionally, governance reforms started with the introduction of financial and assurance control mechanisms, followed by the creation of internal markets and the transformation of healthcare organizations into trusts with the enactment of the NHS and Community Care Act 1990 (Sugarman, 2007). From there, a long series of reforms has aimed at importing governance principles from the private sector into the public arena (Clatworthy *et al.*, 2000). Accordingly, the clarifications on the role of private sector boards and their directors contained in the 2003 Higgs Report have been translated into guidance for NHS boards (NHS Appointments Commission, 2003). More recently, policy-makers have promoted an integrated governance framework, based on the key concepts of patient engagement, clarity of goals, strategic contribution, delegation and assurance (NHS Confederation, 2005). The activity of boards is also influenced by the rules contained in the Combined Code of Governance (NHS Appointments Commission, 2003; Monitor, 2006).

Health sector boards are essentially funded through decisions taken at the central level and hence need to account for and deal with the constraints and limitations imposed by the political system (Rainey and Chun, 2005), in an environment characterized by a complex network of multiple interests and goals (Kickert *et al.*, 1997; Douglas and Ammeter, 2004). Furthermore, they are required to coexist with the trustee dimension of health sector organizations and so their strategic activity needs to give prominence to the long-term consequences of any decision (Dobel, 2005). These types of demand are rarely equalled in the private sector (Cahan *et al.*, 2005). Boards have taken on an increasingly important role in the NHS (Rhodes, 1999; Cornforth, 2003) but there are reservations about their effectiveness (for example Storey *et al.*, 2008). This article describes research aimed at increasing knowledge about how boards work and uncovers areas where improvements are required.

Methodology

Our research was conducted through a range of qualitative techniques (workshops, focus groups, and semi-structured interviews). As shown in table 1 (see p. 364), our sample consisted of 13 NHS organizations, mainly in the north east of England. The trusts' boards comprised 191 members (102 executive directors and 89 non-executive directors), with a median size of 15 members (eight executive directors and seven non-executive directors). The active participants represented 11.5% of the total board population; the inclusion of three senior executives defined as governance professionals given their role in the trusts (i.e. director of governance) increased the reliability of the findings. To achieve triangulation of the data sources and gather alternative views, 17 members of different health care authorities, think-tanks, public auditors and other trusts were also invited to participate in the study.

Despite the limited territorial coverage, the trusts involved in the study represented an adequate cross-section of the overall population.

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Table 1. Participants' roles and affiliations.

Organization	*N*	*No. of board members*	*No. of executive directors*	*No. of non-executive directors*	*No. of executives*
Ambulance service trust	1	2	1	1	
Mental health trust	2	5	3	2	1
Mental health teaching foundation trust	1	1	1		
NHS foundation trust	1	1		1	
NHS trust	2	5	4	1	
Primary care trust	4	5	3	2	2
Teaching hospital foundation trust	2	3		3	
Total (a)	13	22	12	10	3
Appointments Commission	1	1	1		
Clinical governance support team	1				1
Department of Health	1				1
Healthcare Commission	1				1
Health Care Standards Unit	1				1
Independent health care research institute	2	1	1		1
Institute of Internal Auditors	1				1
National Audit Office	1				2
NHS foundation trust	1	2		2	
NHS trust	1	2		2	
Primary care trust	1	1		1	
Strategic health authority	1	2	1	1	
Total (b)	13	9	3	6	8

(*a*) = Research subjects. (*b*) = Triangulation sources.

Following Eisenhardt (1989), the organizations have been chosen for opportunistic (location proximity, existing contacts and familiarity with the history and characteristics of the trusts) and theoretical reasons (adequate sample of the current typology within the NHS). The research was framed with the idea of uncovering similarities (or not) in their patterns of behaviour relative to the application of governance principles and arrangements (Yin, 1994). A summary of the findings and emerging themes is presented in table 2; these are explored in the next sections together with action points for board improvement.

Board dynamics

The structure and composition of NHS boards has remained substantially untouched since they were introduced in the late 1980s (Ferlie *et al.*, 1996; Greener and Powell, 2008). They comprise a chair and a chief executive officer (CEO), responsible for their respective organizational units (board and business respectively—Exworthy and Robinson, 2001). Board directors are divided into:

- Executives—a heterogeneous category comprising career managers and professionals who frequently maintain strong linkages with the medical domain (Harrison and Pollitt, 1994).
- Non-executives—who should represent the general interests of the patients and the outside community at large (Mueller *et al.*, 2004) and be able to transfer their private sector experience (best practice) across sectors (Ashburner *et al.*, 1996; Mueller *et al.*, 2003).

According to the integrated governance framework, trust performance depends on the effectiveness of board leadership (NHS Confederation, 2005) and, therefore, the way they operate (their internal dynamics) is critical to their activity.

We found that too much emphasis is placed on the formal structures of boards and not enough on their processes/dynamics (see table 2—1.1). The simple explanation for this is that it is relatively easy to be prescriptive about structures—number of directors, the different types, number of board meetings, the type of items to be considered etc.—while it is relatively difficult to describe what is needed in terms of process, an environment to help create a fully effective board and so on. Directors frequently act as a set of individuals instead of a collective unit and *de facto* do not really add value to the business. Many participants thought there was an excessive focus from the chair and CEO on their roles, downplaying the need to develop a cohesive and effective board (table 2—1.2). Not enough attention was being given to the other directors (their role, skills and characteristics) and the opportunity to create a unit which brings

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Table 2. Research findings.

Governance matter	Emerging issues	Participants' observations
Board dynamics	1.1: Excessive emphasis on formal structure of boards	'When we talk about governance…we almost always talk about structure…But to me, governance is about strategy, it is about giving direction to the organization and those who work at the upper, middle and lower levels' (foundation trust chair)
	1.2: Excessive focus on chair–chief executive roles and relationship	'A lot of executives felt really uncomfortable about the way the chair and the chief exec. appeared to gloss over what was going wrong in the organization, and they were inherently inadequate in terms of governance principles' (trust executive director)
	1.3: Executives' behaviour towards board activity	'Because the executives didn't like or didn't see the value of the board subcommittees, they tried to sort of sabotage board activity, to use assurance as a tool to complicate the job of the non-executives' (trust chief executive)
	1.4: Non-executive directors at the margins of board activity	'What happens most of the times is that the non-executives are not allowed to challenge, they are not encouraged to fully exercise their duties, so it is kind of problematic for them to perform effectively their functions' (Appointments Commission executive director)
	1.5: Overall board climate	'I used the chief executive reports and did something about team working, and bring the chair to the board, to build a relationship with the other non-executives to make sure that they knew what was going on' (PCT chief executive)
Board processes	2.1: Ticking the corporate boxes	'Boards should stick to the agenda, not with a box-ticking approach, but making sure that things are done properly, that all the members are listened to, that the right process has been followed, that the assurance framework has been respected, and the following actions have been taken accordingly' (foundation trust non-executive director)
	2.2: Difficult to secure challenge and trust	'It comes down to the point of the clarity of roles, to the fact board members have a static or dynamic relationship, to the fact that on the decision day they come to the board effectively briefed, informed and actively participate' (Healthcare Commission executive)
	2.3: Limited information to the board	'One of the very important factors in board relationships is that boards should be effectively and constantly informed and assured that there are not other elements on the agenda. And that nothing is hidden from them. Is this really happening on regular basis?' (trust executive director)
	2.4: Lack of internal consultation process	'It is not a process without flaws, mistakes are made especially in terms of engaging the right people throughout. And it is not as representative as it should be, and lot of people in subordinate positions are still not expressing their opinion' (PCT executive director)
Responsibility versus accountability	3.1: Lack of understanding of personal and collective responsibility	'Trusts can achieve transparency and hence accountability only by mediating all the inner tensions and competitive demands at individual and collective levels, there is a lot of nonsense in the system that is dragging down the performance of boards' (PCT chair)
	3.2: Lack of understanding/ appreciation of the role of governance	'To me, and I think this opinion is shared by many others, governance is about management, is about how you manage your organization. It is about structure and how you organize the business' (Department of Health executive)
	3.3: Lack of open and constructive environment in boards	'Boards and their committees have to improve their standards, their procedures. People need to be engaged, empowered and protected in order to take meaningful decisions. Right now, people are just waiting to point fingers at each others' (trust executive director)
Board overall function	4.1: Insufficient leadership transmitted through the board	'Governance is a leadership matter, it's about transmitting good principles through the organization, but in too many cases leadership and governance are just matters for the top of the organization' (SHA non-executive director)
	4.2: Board isolated from the rest of the organization	'I'm astonished how many boards don't follow up their decisions. Most of the time half of the board is thinking that's not our role, that's not what we're supposed to do. They seem out of touch with their organization' (trust non-executive director)
	4.3: Insufficient engagement of board directors	'Directors need to be engaged, to be shown that there is support for them. But they also need to show more commitment to the rest of the organization. Too often we're far from being clear on what is really going on' (PCT executive director)
	4.4: Insufficient strategic contribution of boards	'Directors have to move from a very inward looking perspective of trust matters to a very much more broad understanding of the issue faced by the organization as a whole' (foundation trust non-executive director)
Board objectives	5.1: Inadequate measuring of outcomes	'We don't think that core standards are measured in the way the service is provided: the way core standards are structured is that they ask you what structure and systems are in place, but what they do not do is to demonstrate the outcomes of these processes, the results of the operations' (trust executive)
	5.2: Failure to appreciate the overall board purpose	'Frequently the focus of the board is just based on activities…is just based on what's going on. Not on if the organization is achieving the targets and the purposes for which it is there for in the first place' (clinical governance support team executive)
	5.3: Insufficient reporting to the board	'My previous organization was performing quite badly, and there was not enough reporting to the board, there was no real chance to check upon executives. So the board itself was performing really poorly on its targets but this was systematically covered' (PCT chief executive)

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out the best of the directors and hence mutual support was often being missed.

Furthermore, executives seemed to consider their real job as being their daily role within the NHS. They often thought they had enough responsibility in their managerial jobs without taking on the board duties which really should belong to the chair and CEO (table 2—1.3). Quite simply, they appear to see little benefit from taking on what are considered additional responsibilities and hence the board becomes an adjunct and distraction. Similarly, non-executives have lamented a general lack of involvement and under-utilization in board decision-making (table 2—1.4). They are not paid a lot (compared to their private sector counterparts), they are often not given sufficient time and/or information to fully understand the detail of the organization and the real issues that need confronting. As a result, they allow the chair and CEO to drive the board and the associated agenda/discussions almost at will.

A final issue is the potential conflict between the chair and CEO, and the executives and non-executives, which then translate into the climate of the whole board (table 2—1.5). In terms of the former, the two activities are necessarily intertwined and the dichotomy of chair/board–CEO/business is far too simplistic. Some chairs/CEOs seemed incapable of agreeing mutually supportive roles both internally and externally, and so the natural tensions between the roles were heightened, especially if one had long-standing clinical/NHS experience and the other did not. Similar fundamental tensions mar the relationship between executives and non-executives, especially when the latter have held a directorship in the private sector.

To tackle some of these issues, the chair needs to ensure that all directors are fully briefed on the range and detail of their responsibilities as directors. Furthermore, directors need to be given the opportunity both within and outside the board to appreciate each other's skills/experience/potential contribution and how they might work together as an effective team. Equally, directors need the time and appropriate environment to break down potential divisions and information and opportunity to discharge their duties.

This will rarely happen by accident but needs to be designed in and actioned. In an ideal world, an experienced chair will be aware of the issues and take the appropriate action, but our experience is that it may need the appointment of a board mentor to help diagnose and design in the necessary actions. However, when it comes to the dynamics between chair and CEO, it is often best if these directors take time out to reflect on and affirm their respective roles and responsibilities. Of course the selection of the board members for their skills/temperament will affect how easily this can be achieved.

Board processes

The integrated governance framework posits that high-performing boards are characterized by trust and cohesion among directors, constructive challenge and effective board processes (NHS Confederation, 2005), based on the idea that individual behaviours play a dominant role in board success (Sonnenfeld, 2002). In contrast, the boards in this study, for the most part, had got themselves into a process rut of ratification and doing just the minimum required, mechanically going through the items on the agenda (table 2—2.1).

Non-executive directors found it difficult to question or challenge health executives and consequently struggled to perform their roles in any sort of meaningful way (table 2—2.2). Accordingly, boards found it hard to design useful models for the tasks at hand.

Another process issue that arose from our research was that decision-making activity was restrained by a lack of internal consultation and by the quality and amount of data provided to boards. Much of the basic data needed to answer simple questions was not produced or was delivered with sizeable time lags, allowing boards to play to the prejudices of individuals (table 2—2.3). In many ways, this is a variant of 'information is power' or a lack of information enables a power status quo to be maintained (Foucault, 1982). The board remains distant from the real issues of the day and serenely oversees matters that are not mission critical.

A second associated issue is a failure of internal channels of communication and information sharing. If the board is run from the top, if there are natural tensions within the board and if data is an issue, a corollary is likely to be communication failure. This has led to boards being unaware of what is happening in their organizations. Similarly, decisions have been taken at board level and have failed to travel down and/or be actioned by the organization.

One method of breaking out of the strait-jacket of boxticking and ratification is to structure board agendas so that these items are dealt with expeditiously at the start of meetings, leaving sufficient time in the remainder of the session for directors to explore and challenge broader strategic/organizational issues. Such exploration and challenge will only be forthcoming if all directors (especially the non-executives) are given

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the opportunity to understand the organization and its issues. A critical factor in this is to have an information system that allows directors to drill down and across the organization in a timely manner; and this should be a critical part of the investment of any health trust. Nonetheless, individual directors have a responsibility to ensure they are aware of issues and can actively participate in board discussions.

Responsibility versus accountability

Since the early 1990s attention has been directed towards accountability within both the private and public sectors (Greener and Powell, 2008). In many ways, this emphasis has been bound up with an increased focus on the importance of performance measurement and management (Hood, 2007). Nevertheless, an emphasis on measurement and accountability allows the individual to hit the defined measures of performance and this removes any need to worry about more general issues of performance. In general, a focus on accountability and specific measures will shift an organization away from constantly searching for ways to improve.

We have evidence that board members (both executive and non-executive) may lack the board and sector experience to question and move beyond simple accountability to responsibility. Given the constant changes in the organization of the NHS, it cannot be easy to keep an eye on what is truly important (table 2—3.1). Moreover, as funding is driven, at least in part, by meeting measures of performance, only the very brave will ignore these measures and pursue the health of an area from a more general perspective.

The complexity inherent in the NHS structure (Hunter, 2005) means it has been difficult for many to fully understand the role played by their specific organization and how this relates/connects with other parts of the system. This lack of clarity is added to by confusion over governance and management (table 2—3.2). Governance is not to do with the day-to-day direction of the organization; rather, it is the creation of the culture and environment which promotes the achievement of the organization's goals across all levels of the business (Sonnenfeld, 2002).

An emphasis on accountability and assurance can also be used as a defensive barrier, providing an excuse to not attend to other important matters. Board members are inclined to ignore issues because if they are not part of the measurement set then they cannot be important. And the costs of taking contested decisions dramatically outweigh individual rewards, helping to create vested interests around particular dimensions of the performance measurement set. According to the participants, individuals have become defensive in their decision-making, fearful of blame and opprobrium (table 2—3.3). This has led to efforts to move risk onto others away from individual responsibility.

The solution is to find ways of ensuring that the potentially useful management by objectives (i.e. accountability) does not become dysfunctional to the ultimate detriment of the organization. Nevertheless, central initiatives are constantly forcing NHS managers to restart and they never have the opportunity to properly and fully embed the practices and behaviours which will ensure quality, cost and timeliness of health practices. In addition, the ICT systems which are critical to management across the whole organization are immature and need substantial investment in a lot of trusts.

These problems will only be overcome when trust directors accept that, while they have to respond to central initiatives, their primary responsibility is to deliver health to their particular domain, making decisions of balance and being their own people. The chair and the CEO will be critical to giving the confidence necessary to the board to take such a stance. A further means of fostering responsibility across the organization is to engage staff in themes which they all own, which is best done on a sequential basis.

The overall function of boards

Trust boards are required to offer leadership and direction which will be achieved through the formulation and implementation of strategic plans (Halligan and Donaldson, 2001). Boards also need to control managerial activity (Zahra and Pearce, 1989). Only a board culture open to constructive challenge from all its members can ensure richness of the board debate (Bevington *et al*., 2005). To add value to the organization, clarity of purpose is required and hence the board needs to establish for itself a defined and recognized role (Nadler, 2004).

Our study highlighted two major obstacles for NHS boards to overcome in order to work effectively:

- Directors (both executive and non-executive) did not offer a consistent set of messages to the organization and did not connect with all the internal stakeholders (table 2—4.1).
- Outside of individual directors' own networks and lines of command, we have seen no evidence of channels of communication directly targeted towards delivering board decisions (table 2—4.2).

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As in the private sector, directors tended to live in isolation (even executive directors) from the rest of the organization. There appeared to be a lack of concerted efforts to connect with the layers immediately below the board (table 2—4.3). As a consequence, directors are not capable of actively understanding the various constituencies and how to interact with them. In addition, participants have narrated stories of boards removed from the strategic organizational and external context (table 2—4.4). The boards we studied were ineffective in translating their activity into clear strategic plans and, therefore, insufficient leadership and direction was being provided to trusts.

To overcome the issues raised here board directors need to make concerted efforts to become visible and approachable to/from all parts of the organization, i.e. through social events, open coffee meetings, dining together, purposefully 'skipping a tier' in organizing meetings, walking the corridors etc. All of these have potential dangers, but if managed properly they can break down the invisible barriers that exist in all organizations and underpin the formal communication policies/systems which enable all members to engage with varied organizational activities. Finally, given the serious risks which exist within health trusts, there need to be formal policies/procedures which allow all members to record potential risks such that management and directors can respond in a timely manner—one easy, but sometimes only partial, solution is a corporate risk register.

Board objectives

Performance measurement and governance by targets, characteristics of a centralized form of control, have been applied to the health sector at the same time as other government initiatives intended to devolve more autonomy and decision-making power to the local level (Martin *et al.*, 2009). However, a performance management system is essentially bound to not capture the inner quality of the service delivered and this, by definition, is a major deficiency when dealing with general health and population well being (Pollitt, 1986).

Many participants have criticised the fact that the current system does not measure the real work performed by trusts (table 2—5.1). In many ways this type of situation has led board directors to become passive observers rather than active designers of the governance of the organization. They seem to have fallen into the trap of ticking predetermined boxes and responding to the latest policy initiatives from the centre, losing sight of the fundamental purpose of the NHS—patients' health and the health of the nation.

The tension between a performance management culture and the wider brief of enhancing health is heightened by the fact that NHS boards have struggled to demonstrate strong financial management and this has driven the centre to push for greater attention to this highly measurable part of management (Klein, 2006). According to our evidence, boards appear to have a tendency of sitting on the fence when it comes to dealing with conflict of interests in performance targets (table 2—5.2).

Like Greener and Powell (2003) we heard of health managers manipulating trusts' performance measurements and related data in order to present individual and group outcomes in a better light. It was not uncommon for trusts to expose those areas where the performance was successful and conveniently hide those others where, in contrast, indicators had not been positive (table 2—5.3). Accordingly, many directors have lamented the limitation of being provided with incomplete information/ convenient data on measured targets, therefore diminishing their ability to assess organizational performance through rigorous board scrutiny.

While there is no easy answer to the issues raised here, one possible set of solutions is for the organization to develop a strategy map which all members can understand and relate to. An integrated ICT system should then be able to deliver measures which allow members to track how they are performing against the parts of the strategy map. Finally, engagement with this type of structure will be enhanced if attention is given to the way the data is presented and made accessible, for example implementing a dashboard approach customized to individual needs and changing organizational requirements.

Conclusions

The research findings suggest that there are still natural tensions within NHS boards and that time and effort needs to be spent understanding the differences and how these can be accommodated and used to the benefit of the collective board. We found that there was a general understanding among NHS boards of the 'what' of governance—structures and basic principles, but more work is required in terms of the 'how'—board dynamics, processes, responsibilities, overall function and objectives are still not overly well specified or widely understood.

A team environment operating on the basis of diffuse trust and constructive dissent creates a

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'mutually reinforcing circle of benefits' (Bevington *et al.*, 2005). This involves a move from a focus on individuals to a collective team effort. More attention needs to be given to fine-tuning the behaviours of NHS boards. They need to move away from the current over-emphasis on the chair and CEO, and board structures. Of course this is not easy as we move from characteristics which are effortlessly defined to soft issues such as environment, relationships between directors, defining individual/team strengths and weaknesses. But this seems a necessary step if boards are to be effective.

Boards have to increase the threshold of their mandatory duties in order to ensure quality of the service, effective partnership, adequate financial management, and the involvement and care of the range of organizational stakeholders, from the internal staff to the local community (Wells *et al.*, 2006). Accordingly, our suggestions for practitioners entail working individually with directors on improving their skills, contribution and visibility within the organization; structuring board agendas in a manner that surfaces challenge and debate; implementing an ICT system that keeps the board and the directors informed on a timely basis; focusing boards on making decisions for their own people and promoting the collective management of risks. ■

References

Allen, P. (2006), New localism in the English National Health Service: what is it for? *Health Policy, 79*, 2/3, pp. 244–252.

Ashburner, L., Ferlie, E. and Fitzgerald, L. (1996), Organizational transformation and top-down change: the case of the NHS. *British Journal of Management, 7*, 1, pp. 1–16.

Bevington, J., Stanton, P., Halligan, A., Cullen, R. and Donaldson, L. (2005), Building better NHS boards. *Clinician in Management, 13*, 2, pp. 69–75.

Cahan, S. F., Chua, F. and Nyamori, R. O. (2005), Board structure and executive compensation in the public sector: New Zealand evidence. *Financial Accountability & Management, 21*, 4, pp. 437–465.

Clatworthy, M. A., Mellet, H. J. and Peel, M. J. (2000), Corporate governance under 'new public management'. *Corporate Governance, 8*, pp. 166–176.

Cornforth, C. (2003), *The Governance of Public and Non-Profit Organizations: What Do Boards Do?* (Routledge, London).

Dobel, J. P. (2005), Public management as ethics. In Ferlie, E., Lynn Jr., L. E. and Pollitt, C. (Eds), *The Oxford Handbook of Public Management* (Oxford University Press, Oxford).

Douglas, C. and Ammeter, A. P. (2004), An examination of leader political skill and its effect on ratings of leader effectiveness. *The Leadership Quarterly, 15*, pp. 537–550.

Eisenhardt, K. (1989), Building theories from case study research. *Academy of Management Review, 14*, pp. 532–550.

Exworthy, M. and Robinson, R. (2001), Two at the top: relation between chairs and chief executives in the NHS. *Health Service Management Research, 14*, pp. 82–91.

Ferlie, E., Fitzgerald, L. and Ashburner, L. (1996), Corporate governance in the post 1990 NHS: the role of the board. *Public Money & Management, 16*, 2, pp. 15–21.

Foucault, M. (1982), The subject and power. In Dreyfus, H. L. and Rabinow, P. (Eds), *Michel Foucault* (Harvester, Brighton).

Greener, I. and Powell, J. (2003), Health authorities, priority-setting and resource allocation. *Social Policy and Administration, 37*, pp. 35–48.

Greener, I. and Powell, M. (2008), The changing governance of the NHS. *Human Relations, 61*, 5, pp. 617–636.

Halligan, A. and Donaldson, L. (2001), Implementing clinical governance. *British Medical Journal, 322*, pp. 1413–1417.

Harrison, S. and Pollitt, C. (1994), *Controlling Health Professionals* (Open University Press, Buckingham).

Higgs, D. (2003), *Review of the Role and Effectiveness of Non-Executive Directors* (DTI/HMSO, London).

Hood, C. (2007), Public service management by numbers: Why does it vary? Where has it come from? What are the gaps and the puzzles? *Public Money & Management, 27*, 2, pp. 95–102.

Hunter, D. J. (2005), Editorial. *Public Money & Management, 25*, 4, pp. 209–212.

Kickert, W. J. M., Klijn, E. H. and Koppenjan, J. F. M. (1997), *Managing Complex Networks: Strategies for the Public Sector* (Sage, London).

Klein, R. (2006), *The New Politics of the NHS: From Creation to Reinvention* (Radcliffe Publishing, Abingdon).

Martin, G. P., Currie, G. and Finn, R. (2009), Leadership, service reform, and public service networks. *Journal of Public Administration Research & Theory, 19*, 4, pp. 769–794.

Monitor (2006), *The NHS Foundation Trust Code of Governance* (London).

Mueller, F., Harvey, C. and Howorth, C. (2003), The contestation of archetypes: negotiating scripts in a UK hospital trust board. *Journal of Management Studies, 40*, 8, pp. 1971–1995.

Mueller, F., Sillince, J., Harvey, C. and Howorth, C. (2004), 'A rounded picture is what we need': rhetorical strategies, arguments, and the negotiation of change in a UK hospital trust. *Organization Studies, 25*, 1, pp. 75–93.

Nadler, D. A. (2004), Building better boards.

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Harvard Business Review, 82, 5, pp. 1–9.
NHS Appointments Commission (2003), *Governing the NHS: A Guide for NHS Boards* (Department of Health, London).
NHS Confederation (2005), *Effective Boards in the NHS?* (London).
Pollitt, C. (1986), Beyond the managerial model. *Financial Accountability & Management, 2*, pp. 155–170.
Rainey, H. G. and Chun, Y. H. (2005), Public and private management compared. In Ferlie, E. *et al.* (Eds), *op. cit.*
Rhodes, A. (1999), Governance and networks. In Stoker, G. (Ed), *The New Management of British Local Governance* (Macmillan, London).
Sonnenfeld, J. A. (2002), What makes boards great. *Harvard Business Review*, pp. 106–113.
Storey, J., Bate, P., Buchanan, D. A., Green, R., Salaman, G. and Winchester, N. (2008), New governance arrangements in the NHS: emergent implications. NHS-SDO Working Paper No. 3, pp. 1–16.
Sugarman, P. (2007), Governance, strategy and innovation in mental health. *Psychiatric Bulletin, 37*, pp. 283–285.
Wells, S., Moyes, B. and Fry, M. (2006), *The Intelligent Board* (NHS Appointment Commission, London).
Yin, R. K. (1994), *Case Study Research* (Sage Publications, Newbury Park).
Zahra, S. A. and Pearce, J. A. (1989), Boards of directors and corporate financial performance. *Journal of Management, 15*, pp. 291–334.

Call for papers: Themed issue on ‘Decentralization and the big society’

Guest editors: Francis Davis, Fellow, Blackfriars Hall, University of Oxford and Fellow of the Young Foundation UK; and Ayman Agbaria, Department of Education, University of Haifa

This issue is scheduled for January 2012 (Vol. 32, No. 1). The deadline for abstracts and proposals for papers is 1 February 2011 to Francis Davis (Francis.davis@youngfoundation.org.uk) by 1 February 2011. Final papers will need to completed by 30 July 2011.

This themed issue of PMM sets out to describe the Big Society in particular and assess approaches to decentralization and the related search for increasing civic responsibility in international context in general. Rooted in emerging UK experience in local and national government and the voluntary and social enterprise sectors, it consequently welcomes British proposals for papers. However, it especially seeks to attract contributors reflecting on experience outside the UK where radical approaches have already been trialled, tested or are emerging. Key topics may—but not exhaustively—include:

- Decentralization of central government departments.
- The principles, opportunities, techniques, and threats of targets, central goals and performance indicators in national state and civic governance.
- The role of local government and neighbourhoods.
- Information transparency, budgets and democratization.
- Mutualization and privatization of state services
- The rise and potential of social business, bottom of the economic pyramid, markets and civic entrepreneurship.
- Civic and social innovation ‘hubs’, ‘labs’ and policy reform.
- Behavioural economics, ‘nudging’, and the idea of ‘social growth’.
- Political management in decentralizing contexts.
- HR, strategy and recruitment for a ‘civic service’ in central government.

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