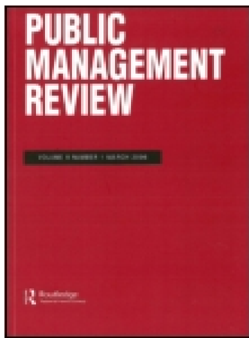

Public Management Review

ISSN: 1471-9037 (Print) 1471-9045 (Online) Journal homepage: https://www.tandfonline.com/loi/rpxm20

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To cite this article: Gianluca Veronesi & Kevin Keasey (2011) National Health Service Boards of Directors and Governance Models, Public Management Review, 13:6, 861-885, DOI: 10.1080/14719037.2010.539113

To link to this article: https://doi.org/10.1080/14719037.2010.539113

Published online: 14 Mar 2011.

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NATIONAL HEALTH SERVICE BOARDS OF DIRECTORS AND GOVERNANCE MODELS

Gianluca Veronesi and
Kevin Keasey

Abstract

This article reports the findings of a year-long research project focused on the activity of boards of directors of twenty-two trusts from the British National Health Service (NHS). The evidence gathered through the use of semi-structured interviews, focus groups, workshops, feedback questionnaires and document analysis indicates that the behavioural dynamics of boards, affected by the dominance of the expert model, act as antecedents of their statutory functions and the implementation of different governance models. Only a portion of the boards involved has effectively incorporated in its modus operandi post-New Public Management (post-NPM) principles of governance.

Key words

Behavioural dynamics, boards of directors, National Health Service, New Public Management, network governance

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Vol. 13 Issue 6 2011 861–885
Public Management Review ISSN 1471-9037 print/ISSN 1471-9045 online
© 2011 Taylor & Francis
http://www.tandf.co.uk/journals
DOI: 10.1080/14719037.2010.539113

INTRODUCTION

In recent years there has been a marked shift from direct government to decentralized forms of administrative practice (Rhodes 1997; Fredrickson and Smith 2003) as the State has come to terms with the need for sharing power and citizen engagement (Kooiman 2003; Farrell 2005; Newman 2005; Greener and Powell 2008). The move towards network or collaborative forms of governance has strongly supported the idea of concerted decision making through the involvement of multiple stakeholders operating at different levels within the system (Kickert *et al.* 1997; Bovaird and Loeffler 2003; Meier and O'Toole 2005; Andresani and Ferlie 2006; McGuire 2006; Ansell and Gash 2008). Raising the level of public interaction (and scrutiny) with a whole range of subjects (individuals, groups and institutions) would link more effectively the delivery of the service to local communities (Douglas and Ammeter 2004; Koppenjan and Klijn 2004; Hogg 2007).

Accordingly, the focus on partnership and network-oriented forms of collaboration in the delivery of the service has given prominence to a different set of priorities for public sector boards: better responsiveness to citizen needs and improved quality of the service provided in primis (Peters and Pierre 1998; Newman 2001; Ferlie *et al.* 2003; Addicott *et al.* 2007). In addition, public sector boards have been given the responsibility of fostering the public good by taking into account a much wider stakeholder community and its multifaceted variety of interests (Vining and Weimer 2005). Thus, collaborative forms of governance are based on the ability to work in partnership and to accept a wider consultation process and shared decision making within the settings of the board (Kickert and Koppenjan 1997; Forbes and Milliken 1999; McGuire 2006; Tyge Payne *et al.* 2009).

So far, nevertheless, there has been little empirical evidence on the impact of the latest governance reforms on the activity of boards, the extant literature being mainly concentrated on matters such as knowledge management, issues of autonomy and wider impact of change programmes on boards' activity (Currie and Brown 2003; Mueller *et al.* 2003, 2004; Hoque *et al.* 2004). The main purpose of this article is, therefore, to fill a gap by looking at how the network governance perspective has been translated within boards' settings and, so, the unit of analysis has entailed a view of network governance from within the organizational level. Precisely, we have investigated if the internal dynamics of boards act as antecedents of the exercise of board statutory functions and the implementation of network-based principles/mechanisms in health sector organizations. In order to achieve greater richness of the data, the evidence has been gathered through the use of semi-structured interviews, focus groups, workshops, feedback questionnaires and document analysis.

The study is concentrated on the UK National Health Service (NHS) in general – reflecting the fact that in the UK health and social care service organizational boundaries have increasingly become more complex and subjected to frequent changes (Bate and Robert 2002; Martin *et al.* 2009). Boards of directors were introduced as a part of the

New Public Management (NPM) reforms of the late 1980s (Ferlie *et al.* 1996; Clatworthy *et al.* 2000). The managerialist approach to public service delivery made boards primarily responsible for increasing the efficiency and competitive drive of public organizations (Clatworthy *et al.* 2000; Farrell 2005). The initial role of boards was, therefore, strictly on and within the micro-organizational level.

The coming into power of Labour in 1997 fundamentally left untouched the structure, composition and statutory functions of boards. Nevertheless, given that the policy design focused on facilitating inter-organizational collaboration (Dent 2005; Addicott *et al.* 2007) and devolving decision-making power closer to the final user/citizen (Greener and Powell 2008; Martin *et al.* 2009), public sector boards have been required to perform an increasingly complex function within a system traditionally characterized by a variety of objectives (patient care, population health, financial viability, etc.) and actors (managers, professionals, politicians, local communities, etc.) whose power relationships can profoundly impact the activity of these boards (Denis *et al.* 2001). We, therefore, expect to see an impact of this further set of challenges on the behaviour of boards.

In the first part of the article we present a brief overview of the NHS context specific literature. Furthermore, we explain our research methodology and the process through which the research design has been modified according to the emergent evidence. In the following section, the interpretation of the findings first concentrates on the different perspectives of health sector boards in relation to key governance principles. Subsequently, we examine the evidence related to behavioural dynamics of boards and the impact that these have on board functions and, consequently, on the implementation of different governance models. The conclusions are then drawn by shedding new light on the still under-researched impact played by behavioural dynamics of boards on the activity of public sector organizations.

NHS CONTEXT OVERVIEW

The NHS entails a multifaceted entity, where new organizational governance mechanisms have been introduced and developed extensively at an unprecedented level of pace and intensity (Bamford and Daniel 2005; Kuhlmann and Allsop 2008). It also represents an example on how different types of governance models (hierarchy, market and network) can coexist within a sector (Rhodes 1997; Exworthy *et al.* 1999; Newman 2001). Following the NPM paradigm the declared ambition was to secure greater efficiency and value for money within the public sphere (Hood 1991; Ferlie *et al.* 2003; Pollitt and Bouckaert 2004). For that reason, the reforms brought the creation of internal markets, the use of contracts and the transformation of health care organizations into semi-autonomous trusts (Farrell 2005; Greener and Powell 2008).

After 1997, however, there has been an increasing focus from policy makers on the adoption of collaborative forms of governance – what is here defined as the post-NPM

model – on the assumption that these would increase flexibility and responsiveness (Ferlie *et al.* 2003; Currie and Suhomlinova 2006; Addicott *et al.* 2007; McMurray 2007). Decisions taken locally are assumed to be potentially more effective for patient care and to improve the patient experience (Allen 2006; Dent 2006; Greener and Powell 2008). So, power and control have been devolved to the local level providing public sector boards of directors and their organizations with greater autonomy in decision making and assessment functions (Currie and Brown 2003; Hoque *et al.* 2004).

At the same time, nevertheless, there has been evidence of 'stickiness' of the NPM-theme within other strands of policy. For instance, the resistance of market-forms of governance is evident in policy mandates such as Patient Choice (the right for every patient to select the form and location of the treatment) and the declared intention to increase the diversity of provision through private and third-sector enterprises. With reference to hierarchical governance approaches, World Class Commissioning (a centrally mandated model of service commissioning for Primary Care Trusts) and Payment by Results (the cross-link between funding availability and organizational performance) have clearly indicated the aim of central authorities to maintain a direct control on the activity of trusts. Essentially, the presence of 'command and control' (Greener and Powell 2008) and market approaches suggests that the network model is far from having fully replaced the other two governance forms.

In addition, boards of directors of health care organizations are forced to deal with further sector specific contingencies. These organizations traditionally comprise a group of professionals – frequently defined as clinicians – who are highly specialized and with definite values and behaviours (Meijboom *et al.* 2004; Tagliaventi and Mattarelli 2006). Clinicians have historically prioritized the maintenance of clinical and care standards while managers have had an inclination to emphasize cost control and resource optimization (Guven-Uslu 2006; Greener and Powell 2008). In spite of the dearth of research on the impact of the presence of clinicians on the dynamics of health sector boards, this has clearly had (and continues to have) a tangible influence on the application and effectiveness of governance principles at board and organizational levels (Dent 2005).

Nonetheless, the 'great divide' between clinicians and non-clinicians does not represent a unique potential source of tension between board directors. First, the number of clinicians on boards remains fairly limited and hence the conflict mainly arises in relation to boards and clinicians-turned senior managers within trusts. In addition, the introduction of the managerialist culture and the emphasis on financial performance for health sector organizations has created a new generation of professionals – those with a strong accounting/financial background – which has steadily increased its influence and control on the proceedings of many boards. Indeed, since the early 1990s a significant part of the recruitment and training of board directors has been oriented towards applicants with recognized 'numerical' skills preferably honed through a stint in private sector organizations.

The adoption of NPM principles has given prominence to a different type of expertise, one aimed at improving the financial performance of trusts as well as creating a new type of dynamic (and tensions) at board level. Accordingly, the Appointments Commission, the independent body responsible for nominating directors and identifying their training needs, has recently underlined the importance of drawing into the public sector applicants from prominent private sector organizations as means of allowing the NHS to obtain the 'benefits of commercial experience and skills' (Appointments Commission 2008c: 2). The focus on business-type skills and financial savvy of board directors has nevertheless created a counterproductive effective: the danger of giving excessive power to another group of experts. Even the Chief Executive of Monitor, the independent regulator of Foundation Trusts (FTs) which has historically kept a close eye on hospitals' financial standards, has suggested that there seems to be an excessive eagerness for financial acumen to dominate the ideal skills set of a board at the expense of a more rounded and diverse representation of skills (Appointments Commission 2008a).

RESEARCH DESIGN AND METHODOLOGY

The article reports the findings of a year long research project completed by the end of 2008. The study was conducted through the involvement of twenty-two NHS organizations mainly concentrated in the north-east of England (seven Primary Care Trusts (PCTs), eight trusts and seven Foundation Trusts (FTs)). PCTs, which act as both commissioner and provider of services, were involved in the research in relation to both functions but with a closer look at the provider role. FTs, created in 2003 as a new form of public benefit organization, are hospital trusts with a two-tier board structure, where a board of governors supervises the activity of the board of directors. In spite of the policy makers' intention, the governors are struggling to make an impact and, as confirmed by the study participants and reports leaked to the press (Butler 2008), their function has been so far restricted to ratifying decisions taken by the management board. We have, therefore, focused our investigation on the board of directors. Finally, trusts have represented the prototypical organizational form for hospitals offering acute or mental health care services since the end of the 1980s. An ambulance service trust was added to enhance the representativeness of the sample.

Intentionally, we have focused the investigation only on those organizations that have a direct contact with patients, the ultimate user of the service. The other boards and organizations included in the study, operating in the middle-tier of the NHS (i.e. in between the Department of Health and the providers) have had the function of supplying further interpretative cues and an 'insider' feedback on our analysis. In order to improve the significance of the research and the internal validity of the findings, the participants were selected according to their actual roles, working experience and familiarity with governance matters. A total of thirty-seven board members and senior

managers (sixteen executive directors, fourteen non-executive directors and seven senior executives) with governance roles in their trust were engaged in the research process. The organizations as a whole were also constantly involved in the sensemaking activities for comments and observations. Thus, the interpretation of the findings was scrutinized and evaluated by the participants and other members of their organizations to provide a further robustness check to our own analysis (Yin 1994).

Triangulation of the data was employed to increase reliability and to validate our interpretation of the evidence (Eisenhardt 1989; Yin 1994); seventeen members of different health care authorities/quangos were, therefore, involved in the study (i.e. Department of Health, Strategic Health Authorities, NHS Appointments Commission, Healthcare Commission – now Care Quality Commission, National Institute for Clinical Excellence, NHS Institute for Innovation and Improvement, and Monitor). Because of their prominent role within the system, these participants have an ongoing relationship with the whole range of health care organizations (Davies 2007). Presenting the data gathered to members of central authorities and semi-independent bodies has enhanced the explanatory power of the findings in the sense that the significance of the research outcomes can be extended to the wider NHS board population. Thus, at the plenary session (Table 1: *1.6*) all the participants and the members of health care authorities and quangos were asked to provide their views on our interpretation of earlier findings.

Further triangulation was achieved by comparing the evidence collected through the field work with the one gathered through document analysis. With reference to the latter, we gained meaningful insights into boards' proceedings by looking at the minutes of the meetings as these entail a brief account of the overall debate. Moreover, within the research team – in total seven members included the authors of this article – there was ongoing debate and discussion in relation to the data progressively accumulated. A range of qualitative methods (semi-structured interviews, workshops, focus groups, feedback questionnaires) was utilized to understand the multi-faceted aspects of governance principles and forms at board level. The main focus of the research activity has been to look at boards' behaviour in relation to the implementation of network-governance principles within trusts and if these have been effectively incorporated in boards' internal dynamics and processes.

The use of qualitative approaches has been suggested in particular where the policy environment is complex, as in the modernization programmes of health and social care (Spencer *et al.* 2004). Every participant was interviewed twice, first to gather the initial data and then to facilitate sensemaking and relevant observation. Workshops and focus groups had the function of enhancing participant contribution at the early stages of the research process. The semi-structured interviews have provided the main body of the data while the focus groups have been used to originate ideas and to confirm the interpretations of the authors. Questions in interviews and focus groups were kept intentionally open to give participants the opportunity to express themselves freely without being instructed/biased by our intervention (Silverman 1993). We investigated

Table 1: The research process and its outcomes

Activity		Time	Objectives	Outcomes	Implication
1.1	First contacts with study participants and confirmation of availability from selected trusts	*Months 1–2*	To explain the research idea, the intended outcomes and their role to study participants	Understanding of study feasibility and definition of sample size and characteristics	Trusts selection driven by theoretical as well as geographical opportunistic reasons
			To formalize the research design and obtain access to internal information	Formulation of primary data collection strategy and overall project timetable	Relatively limited number of clinicians initially involved in the research project
1.2	Gathering of secondary data	*Month 3*	To undertake document analysis on the participating trusts	Exclusion of trusts unable/ unwilling to provide access to their internal documents	Poor data quality and quantity for some boards and trusts in terms of their internal activity
1.3	Research team meetings	*Month 4*	To analyse and discuss diverse theoretical perspectives on public governance	Formalization of the theoretical model underpinning the research design	Researchers' previous experiences showing various and conflicting anecdotal evidence on boards
			To organize the plenary session activity according to specific subthemes	Redefinition of the overall role of boards according to extant literature and policy makers' expectation	NPM and post-NPM paradigms co-exist throughout the NHS
1.4	First plenary session with board members (focus groups, workshops, storytelling and individual interviews)	*Month 5*	To gauge how participants interpret public governance principles at board level	Confirmation of the existence of a common platform in terms of boards' internal functions, composition and size	Different views in relation to the prevalence of one specific governance model

(*continued*)

Table 1: (*Continued*)

Activity		*Time*	*Objectives*	*Outcomes*	*Implication*
			To engage participants in discussions around the internal and external role of boards	Diffuse perception of boards as private sector-type organizational devices	Strong sentiment against wider political engagement in some boards
			To understand how governance principles are mirrored within board activity	Doubts over the added value function of stakeholder engagement in service design and delivery	Conflicting evidence of concrete implementation of network-based forms of governance for some trusts
1.5	Research team debrief	*Month 6*	To identify common themes and points in need of further exploration according to the evidence gathered	Inward looking view of board role shared among many participants	Refocusing of the research design according to the early research findings with more focus on internal board dynamics
				Limited relevance given to citizens' voice in some boards	Stakeholder voice on a secondary level of importance in some boards
				Lack of confidence in collaborative models	Emergence of the limitations of the expert model
1.6	Plenary session with members of health care authorities and quangos (focus groups and individual interviews)	*Month 7*	To gather a different perspective on the public role of boards	Several trusts finger-pointed for their inability to implement partnership models	Confirmation of the existence of mixed views regarding the principles dictating boards' activity

(*continued*)

Table 1: (*Continued*)

Activity		*Time*	*Objectives*	*Outcomes*	*Implication*
			To seek an insider's interpretation of the early research outcomes	Suggestion to concentrate on the troubled relationship between professionals and non-professionals	Recognition that health care authorities and quangos are scarcely involved and only moderately aware of trusts' activity
1.7	Research team debrief	*Month 8*	To re-analyse the data through triangulation of the sources	Sensemaking pointing towards the need to focus on NHS modus operandi	Detailed evidence of the board decision-making process yet to emerge
				Recognition that network-based governance principles are yet to be fully implemented within several trusts	NPM principles still exercise a firm stronghold on the activity of many trusts
1.8	Second plenary session with board members (focus groups and individual interviews)	*Month 9*	To better investigate the internal dialogue of boards	Different perception of patient needs between clinicians and the other directors	'Horns effect' between directors with and without medical experience
			To understand the role of professionals within board settings	Boards relying heavily on the contribution of the expert(s) in their decision making	Several boards lack effective group dynamics in relation to network-based activities
				Complex issues are predominantly tackled through known and tested solutions	Many boards seem stuck with the tame or crisis approach

(*continued*)

Table 1: (*Continued*)

Activity		Time	Objectives	Outcomes	Implication
1.9	Research team debrief, participants feedback and final sensemaking	*Months 10–12*	To explore further boards' behavioural issues	Several board members are looking for the 'right' governance model	The study outcomes do not provide totally unambiguous answers to the research questions
			To design and send out a feedback questionnaire for study participants	The contribution of elected politicians is in many instances neglected	The principle of democratic legitimacy does not sit on the internal agenda of many boards
			To analyse further the research findings in light of the participants' comments	Concerns over the effectiveness of collaborative forms of governance	The research sample is split between boards comfortable with post-NPM perspectives and boards that still operate according to NPM discourse

the difference in the findings between the types of trusts involved but we did not attain any significant result as the behavioural characteristics were randomly spread across boards. Essentially, the analysis suggests overlapping results across boards in relation to the organizational type. Table 1 describes the detail of the research process adopted here.

We initially concentrated our efforts on securing the participation of a minimum number of organizations from the three groups of trusts (PCTs, FTs and trusts) and negotiated access to their internal documents. We, consequently, narrowed down the sample due to the refusal of a certain number of trusts to allow board representatives to take part in the study. In addition, some other targeted organizations were excluded because of poor/insufficient data in relation to their internal activity. At the beginning of the project, we realized that the participation of directors with a medical background may have been limited. Even if this was not considered a major issue as clinicians remain, to date, relatively uninterested in taking on managerial roles (Appointments Commission 2008b), we, nevertheless, made a concerted effort to try to engage more clinicians in the project and, following further requests to individuals and their organizations, finally secured the participation of a total of five medics and two chief nurses out of thirty-seven interviewees.

In the first plenary session, participants were given the freedom to interact and debate on many different issues related to NHS governance, ranging from wider organizational governance concerns to more specific board and director role-related discussions. We provided some general common themes drawn from the extant literature and our experience of working with NHS boards but leaving discussions open to facilitate the emergence of evidence closely related to practitioners' activities. Thus, the data were first reorganized according to macro themes, within each theme we, then, proceeded to analyse the findings through an interpretative approach led by the theoretical framework as well as being open to inductive insights. Through the synthesizing process and moving back and forth from the data, we gave prominence to new themes and, therefore, particularly concentrated on those topics that seemed more in need of further investigation.

As expected, the outcomes of this session were extremely rich in terms of themes and points of analysis, but they also provided very different views and conflicting evidence in relation to the perception and interpretation of the current governance models by boards (Table 1: *1.4*). From a theoretical perspective, this supported the claims by those scholars who have argued that mixed governance models persist within the NHS (in primis Exworthy *et al.* 1999). From a practical view, it partially forced us to redesign and refocus the further development of the research process. Moreover, it gave us a strong indication to concentrate the investigation on the factors that were pushing boards alternatively towards the implementation of NPM or post-NPM principles. This new direction in the research was supported by the opinions of members of health care authorities and quangos who, themselves, appeared to have different views of the role of boards as determined by the hybrid model of governance (Table 1: *1.6*).

As a result, in the last stage of the research process we decided to focus on the factors that were influencing the decision-making process of boards. Effectively, we concentrated on the hypothesis that the implementation of different models of governance was dependent on the behavioural aspects of boards' activity. Specifically, we were keen to understand the nature of the impact of the individual and collective dynamics of board directors on the leadership, monitoring and strategic functions of boards. In the last plenary session we, therefore, steered the discussions towards the emergence of views related to the relational aspects and internal working patterns of boards. What emerged was that the NHS model of management based on the supremacy of the expert was, at least in some settings, still dominating board proceedings and, subsequently, dictating the implementation of governance principles (Table 1: *1.8*).

GOVERNANCE PRINCIPLES AND NHS BOARDS

Before examining in depth the data related to the activities of NHS boards, we provide evidence of the way some key governance principles are operationalized in the boardroom, illustrating how the presence of a non-unified governance model can leave room for different implementation approaches. Accordingly, boards have been divided into two groups, one which seems to be mainly driven by NPM principles and another one which appears to follow the post-NPM model. As mentioned, this division runs across all three types of trust involved in the study. It, nonetheless, entails a grey area that does not allow for a precise quantification as there are overlapping features among the behaviour of boards.

The first principle under examination consists of the generation of public value within board settings (Table 2: *2.1*). On the one hand, there are boards ideologically close to the NPM perspective suggesting that first and foremost they are required to oversee the running of a business and hence to improve the performance of the organization in an economic sense (financial viability, efficient use of resources, meeting centrally determined performance targets and so forth). Thus, the added value is measured in the form of efficiency gains and output improvements. On the other hand, other boards emphasize the idea that the provision of high quality health care services entails the first level objective of every NHS organization and business-type concerns, in spite of their importance, should be kept on a subordinated level. Therefore, added value, whatever its precise characterization might be in the local context, is defined in terms of achieving higher effectiveness and better quality outcomes for patients.

Second, we have registered conflicting visions in relation to the concept of democratic legitimacy in the activity of trusts (Table 2: *2.2*). The modus operandi of some boards seems oriented towards avoid dealing on concrete terms with representatives of the local population and, in particular, with elected politicians. Thus, if the involvement of politicians is a mandatory element in their consultation

Table 2: Governance functions and NHS boards

Dimension		*NPM driven boards*		*Post-NPM driven boards*	
2.1	Public value generation	'Our business is health' (Executive, trust)	Added value measured in the form of efficiency gains	'Health is our business' (Non-executive, FT)	Added value measured in the form of effectiveness at the local level
2.2	Democratic legitimacy	'If only the politicians weren't involved! We're victims of the [political] system' (Chief Executive, PCT)	Politicians marginalized to a mere formal involvement	'How do we understand if we're operating in the interest of the local community? We simply ask politicians to be a part of our decision-making process' (Chair, trust)	Politicians involved in making judgement about public resources
2.3	Collaborative ethos	'We don't need to be tied up with other agencies, bodies, local authorities, voluntary organizations or whatever the Government is thinking of' (Executive, FT)	Independence as a simpler and more manageable form of governance	'We can use the built-in capabilities of other organizations without committing many resources. That can only generate positive outcomes' (Executive, PCT)	Partnership approach as more powerful and synergistic form of governance
2.4	Patient experience	'Patients are customers, and if they are not happy they are certainly entitled to go elsewhere' (Non-executive, trust)	Quality as determined by individual patient choice	'Everyone has to know what we're here to do, and what are the responsibilities and consequences of our decisions and behaviours on the outside world' (Chair, FT)	Quality as expression of a wider stakeholder involvement

process, like in the case of PCTs and FTs, this is perceived as a formal requirement rather than a value adding activity. Essentially, what frequently happens in these boards is a subtle, 'political' process as representatives of elected bodies are invited to take part formally but in actual fact are kept at the margins of the board decision-making activity. In contrast, other boards see the contribution of local politicians and the complex network of private and third sector organizations operating in the health sector as a complementary part of their trusts' decision-making process and hence a keystone in terms of making judgements about the use and destination of public resources. So, some PCTs have established comprehensive consultation processes with their stakeholders when required to identify which areas of their 'activities' are in a greater need of support or when, due to limited availability, problematic decisions over the allocation/ investment of resources have to be taken.

Furthermore, contradictory views exist on one of the central principles of network governance – the inter-organizational collaborative ethos (Table 2: *2.3*). According to one perspective, partnership agreements represent overly bureaucratic processes lacking in leadership and direction as well as being characterized by shortcomings in the management of individual and collective tasks. Moreover, it has been suggested that trusts are placed in a 'middle of the road' situation because they are required to operate collaboratively but then assessed on the basis of their individual performance. Essentially, the disadvantages for trusts to follow the partnership mandate outweigh the incentives. In contrast, directors of boards closer to the post-NPM model have stated that their decision-making processes aim to recognize many sorts of expertise and be open to diverse contributions in order to generate wider benefits to patients and local communities. Thus, we have observed how mental health trusts, in line with the established community-based partnership tradition, seemed to rely more evidently on the involvement and support of private and third sector organizations in their activities. Conversely, as suggested in the literature (Evans and Forbes 2009), we have not observed much evidence of a common ground in the provision of acute care, where trusts have shown less motivation in setting up collaborative forms of management.

Fourth, the presence of governance principles stemming from different paradigms has emerged in relation to one of the key targets of recent policy directives (Table 2: *2.4*): namely, the improvement of patients' experience of NHS services (Dowling *et al.* 2008; Greener and Powell 2008). Based on a market perspective, some boards define user satisfaction in terms of the quality of the service delivered as a form of individual patient choice; that is, if the customer is not satisfied then he/she will exercise the right to exit and eventually choose a different provider. For other boards the patient experience entails the recognition of legitimacy and approval from the citizen, who is perceived as the ultimate 'shareholder' of the publicly funded health sector. As pointed out by a Chair of an FT, 'what matters is what really matters for our stakeholders'; fundamentally, NHS boards have a duty to be receptive and capable of transferring citizens' voice and feedback into organizational activity.

ANTECEDENTS OF GOVERNANCE MODELS AT BOARD LEVEL

As seen in the previous section, the data gathered have highlighted a split in the sample boards under investigation: some of them have emerged as organizational governance devices substantially integrated with post-NPM principles, while others have appeared remote from the implementation of the network-based model of governance. We, therefore, investigate the hypothesis that the barriers to the implementation of post-NPM principles stem from engrained behavioural dynamics within board settings. In Table 3 we report the evidence related to the behavioural attributes of NHS boards.

The dominance of the expert model

In line with a common tradition in NHS-based research, our study shows that the management–clinicians interface is still characterized by inner tensions at board and senior management levels. As summarized by one executive director, 'the former tend to be driven by the voice of the patients and the latter tend to be driven more by the needs of the patients'. This clearly represents a simplified view of a long-standing issue which cannot be generalized to every board of directors, but undoubtedly in some settings a 'horns effect' – as defined by a Chief Executive – persists between directors with a medical background and those without this experience. On the manager side, patients' needs tend to be seen as a customer demand and treated as such, whereas on the clinicians' side the concern mainly involves identifying and fixing the problem.

Nevertheless, it is worth noting that as much as the issue of latent tensions between clinicians and non-clinicians still represents a focal point in board behaviour, many participants have appeared more concerned with the financial side and risk management exposure of trusts' activity. Essentially, many directors manifested their worries in dealing with problems for which they lack the necessary individual knowledge and, thereby, they tend to 'play safe' and defer to the opinion of the expert. Essentially, there has been a general increase in the individual accountability of directors in matters where they can be at best described as 'amateurs', as in the case of complex assurance processes (see Dowling *et al.* 2008).

The evidence shows that in several boards the NHS dominant model of professionalism (from a medical or a financial perspective) dictates board proceedings, in the sense that individual expertise in content is valued and given prominence. This creates a challenging dynamic for board decision making: the view of the expert becomes difficult to discuss/argue against unless there is contrarian evidence (Table 3: *3.3.4*). The negative consequences of a board discussion predominantly dominated by the expert perspective are, then, amplified when boards are required to deal with complex issues. By definition, these necessitate a unified approach based on collaboration, agreement on common values, collective learning and openness to feedback (O'Toole 1997; Williams 2002). Being complex issues based on non-linearity

Table 3: Impact on board of directors' behavioural and functional dimensions

Dimension		*Evidence*
Board behavioural dynamics	*Individual behaviour*	*3.1.1* – I believe that it is important for directors to understand that they are doing things because it's necessary . . . directors frequently ask questions, but they don't get into details, sometimes they don't seem to grasp the importance of it. (Governance Director, PCT)
		3.1.2 – We never had a serious conversation as a team, we did go down the route of blaming the others and that was the end of it. (Senior Manager, trust).
		3.1.3 – Nothing difficult ever got asked because the reports that went to the board were kind of lovely, and consequently everybody felt very uncomfortable in the sense that things were done in the way they should have not done. (Chief Executive, trust)
		3.1.4 – The dynamics of the board are like a series of individuals making their points. When someone is challenged it is taken personally and any attempt of engagement is found distressing. (Executive Director, PCT)
		3.1.5 – An effective dialogue requires a two-way discussion without prejudice bases. Rarely did we have some of it in the boardroom. (Non-Executive Director, trust)
	Collective behaviour	*3.2.1* – My experience with the NHS is that we all have got our priorities, so what is important to me, my deadline, is not necessarily important compared to what is important for someone else. (Governance Director, PCT)
		3.2.2 – Effectively there were two boards working, one chaired by a non-executive director, who summoned executive directors and asked them all sorts of questions. And because the executives didn't like or didn't see the value of the non- executives, they tried to sort of minimize their role. (Chief Executive, trust)
		3.2.3 – If the scope of governance is to make sure that we have an organization fit for purpose, and we defined that purpose as providing health care to the local community, ultimately we have all the different versions of it depending on our organizational and professional background. (Executive Director, trust)
		3.2.4 – This is possibly one of the reasons for the inner tension between professionals and managers within boards. Professionals frequently do not know what the structure and role of the boards are about . . . there are differences between different professional groups and within professional groups. It is a quite complex organization to manage. (Non-Executive Director, FT)

(*continued*)

Table 3: (*Continued*)

Dimension		*Evidence*
Board functions	*Leadership*	*3.3.1* – The board had gone to sleep, it listened for a long time to the problems without engaging in any action, it needed to show more interest but it was far too passive and not giving enough direction and presence to the organization. (Non-Executive Director, trust)
		3.3.2 – Goodness knows how we ever get things done. We have to constantly reconcile the tensions rather than solving the complexity. (Chief Executive, trust)
		3.3.3 – There is a clear disconnection between the board and the next tier down, especially with the senior managers and consultants. (Non-Executive Director, FT)
		3.3.4 – We have a dominance (a tyranny actually) of the individual, the 'I', the expert. (Chair, trust)
	Monitoring	*3.4.1* – What I'm doing as Chief Executive is saying to my senior managers this is what it matters to us, this is why we are here, you go away now and you try to deliver it, and we ask in some time how successful you are. Do you think I'm really going to know what is going on in the business? (Chair, FT)
		3.4.2 – Sometimes the heads [*heads of departments*] are giving the board a blind reassurance, or write a report that says everything is fine when it is not, and the report is just signed off by the board. (Chief Executive, FT)
		3.4.3 – Well, our board was simply not able to understand why people were not doing what they were supposed to do. (Non-Executive Director, trust)
		3.4.4 – One of the challenges in developing the board assurance framework [*risk management tool*] is that we have the risk managers, and they sit in a room, on their own, and they write the risk assurance framework. It is done in a very isolated way, and then it is given to the trust board, and the trust board has a look and says 'that's about right'. (Executive Director, trust)
	Strategic decision making	*3.5.1* – Honestly, decisions are made through the higher ranks of the organizations rather than the board of directors. (Governance Director, PCT)
		3.5.2 – We did have to face the reality of the situation without mediation, we did have to deal with it as if it was almost something we had to do immediately, it was almost as if the board of directors didn't want to come up with some really meaningful suggestions. (Governance Director, PCT)

(*continued*)

Table 3: (*Continued*)

Dimension	*Evidence*
	3.5.3 – If we say that rhino consultants have a project, we should be able to understand what they are saying to us even if we don't have the competence as rhino consultants have. However, the governance process is putting on a second tier the collective assessment on the matter against the simple opinion coming from the consultant. (Non-Executive Director, trust)
	3.5.4 – Boards need to get away from an issue-based approach and to be more focused on the changes that have to be introduced in the organization. But this is not going to happen if they can't have a whole picture of the organization. (Chief Executive, trust)

and unpredictability of interconnected relationships of events and agents (Alter and Hage 1993), an approach based on rigid differentiation of tasks, strict hierarchies and fixed functional separations is ill equipped to find effective solutions. Thus, as heard in the focus groups, in board discussions the problems tend to be treated in compartmentalized parts as the relative solutions are drawn from the knowledge repositories of separate individuals (Table 3: *3.5.3*).

Moreover, the NHS has a documented history of achieving results by applying strong project management principles and centralizing authority and control (Poxton 1999; Bate and Robert 2002). As suggested by previous studies (Ling 2002; McGuire 2006; Greener 2008), control and decision power within organizations have mainly been kept inside the boundaries of the expert model and the management of complex problems has struggled to benefit from a collective approach. In the opinion of many participants several boards seem to tackle problem solving by either classifying issues as tame (simple problems with linear cause and effect solutions that can be performance managed) or crisis (where everyone gets their sleeves rolled up and individual conflicts/ differences are set aside). The former approach tends to oversimplify discussions and is likely to be effective only when known issues are faced. The latter has the potential to achieve far greater results due to the collective drive but it is not sustainable in the long run.

Basically, decision making in some health sector organizations appears to be fragmented because problems tend to be solved through unilinear acts, in the sense that these are broken down into neatly defined components and the expert in the field tackles the specific component, for example, the planning of a heart surgery operation (Grint 2005). Open questioning is also severely limited as nobody is interested in challenging the superior authority of the expert and the internal dialogue is driven only by the contribution of few voices. Consequently, the boardroom loses its function as a forum where alternative/conflicting views and opinions are given space and thoroughly

discussed. The collective aspects of the decision-making process – the collegiality of the final decision – are set aside in favour of more practical but less effective solutions.

Implications for board behavioural dynamics and functions

The dominance of the expert model in decision making has, understandably, a powerful impact on various aspects of the activities of boards. Boardroom discussions seem to suffer from a lack of built in capabilities to work as a collective unit as individual expertise is given prominence at the expense of a holistic approach to problem solving. As a corollary, the behavioural dynamics of the board act, effectively, as antecedents of different governance models.

To begin with, from the field work it emerged that the debate within some boards appears to be unable to generate collective outcomes as individual biases and self-preserving behaviours dominate the agenda (Table 3: *3.1.2/3*). Different reasons have been pointed out for this state of affairs: directors (especially the non-executives) do not seem to receive timely and thorough information on the trust activity and hence they are not able to engage in constructive criticism; many directors appear to lack sufficient knowledge of individual responsibilities/roles and, ultimately, key governance principles are interpreted differently within the same board settings (Table 3: *3.2.4*). Consequently, individual and collective tasks are disjointed and treated independently and, in particular, the non-executive directors are scarcely allowed to interact and engage in the board debate (Table 3: *3.2.2*). Boardroom discussions are, therefore, led to a point where they lack adequate challenge and individual priorities turn into forces that undermine team-based principles and values (Table 3: *3.1.4/5*). This tends to be aggravated by the fact that several boards seem to interact only marginally with the rest of the organization, which leaves the board to operate in isolation.

Moreover, the differences in professional background and individual expertise appear to have an impact on the definition and perception of fundamental organizational values (Table 3: *3.2.1*). For instance, the core principle of providing adequate health services to the community has been unanimously recognized as the bottom line goal of every trust and, thus, the common ground on which the strategic direction of trusts is built on. Nonetheless, the principle also seems to originate substantially different interpretations depending on directors' professional backgrounds (Table 3: *3.2.3*). Thus, the concept of public value generation might be associated with more financially oriented measures of organizational success (e.g. accounting performance) rather than gauging organizational effectiveness in relation to the multi-faceted needs of patients. Similarly, patient experience might be preferably assessed on the basis of the achievement of central targets instead of more complex measurements of stakeholders' satisfaction. Outside the realm of conscious board choices, the inability to work with an inclusive modus operandi weakens both the centrality of the concept of democratic legitimacy and the prominence given to the collaborative ethos. After all, if these are

not pursued within the safe and close environment of board settings, it is doubtful if they can have any meaningful impact in relation to the involvement of external actors, agencies, bodies and so on.

Essentially, individual and collective 'dysfunctional' (from a collaborative management perspective) dynamics within board settings represent the ideal terrain for the NPM model of governance to thrive given that it is here that the collective and partnership aspects are given a far less crucial role than in the post-NPM model. The behavioural dynamics of many boards seem to dictate the implementation of a governance model that requires a relatively 'simpler' (or, perhaps, only more familiar) board role, for example, ratifying decisions that have already been discussed at the expert level. The boardroom should represent the round-table where different views are presented, motivated and comprehensively debated. Nevertheless, the expert is not used to being confronted and hence not willing to accept constructive criticism; the 'non-expert' acts defensively, unwilling to be exposed to the dominant view (Table 3: *3.1.1*). As a result, the board dialogue becomes a collection of individual inputs and remains close to contributions from outside its narrow settings, de facto creating obstacles to any meaningful, and not merely formal, involvement of stakeholders.

In turn, the internal dynamics have a noticeable influence on how the board functions are exercised. First, the leadership role of the board seems to be weakened by the dominance of the individual expertise and the inner tensions running through directors' relationships (Table 3: *3.3.2*). These tensions create considerable obstacles for outsiders to be involved in the board decision making and, if this happens, their inputs are seldom transmitted to the rest of the organization due to the passive attitude of boards (Table 3: *3.3.1*). Moreover, boards end up working in isolation as the focus on the individual compromises a more open and receptive approach (Table 3: *3.3.3*). Again, this plays in favour of maintaining the status quo – acquaintance with principles dictated by the NPM model – rather than the adoption of more articulated governance models. Thus, democratic legitimacy and a collaborative ethos are unlikely to be systematically internalized and supported as crucial organizational values when the board itself cannot express a unified leadership direction for the trust.

Second, boards are affected by a scarce awareness of internal proceedings and, therefore, are not in a condition to understand thoroughly how the organization is performing (Table 3: *3.4.1/3*). This insufficient transparency of organizational matters affects the board control function as this is driven by the articulated initiative of individuals rather than entailing a collective effort (Table 3: *3.4.2*). In essence, behavioural dynamics represent a decisive factor in terms of board ability not only to decide how public value should be pursued but also when and how to monitor the progress towards organizational goals. Intuitively, for boards that only have a partial/ distorted picture of the activity of their trusts, the use of performance indicators, as determined by central authorities, represents the only viable solution for the exercise of the monitoring function. These boards will entirely be dependent on the targets being hit to be reassured that service quality issues are sufficiently covered, and hence the

responsibility to achieve quality improvements is conveniently placed on the central authorities. Vice versa, in the post-NPM model, the central idea is that the service should be tailor-made to the needs of patients and the local population through collective decisions taken at the level of trusts. This entails a two-way process: on the one hand, the collective dynamics need to allow boards pushing further the organizational boundaries in terms of the openness of their debate; on the other hand, boards have to pursue transparency through increased stakeholder involvement in the monitoring of the overall performance of their trusts. Only a portion of the boards involved in the study seems to have embraced a comprehensive stakeholder participation in their activity.

Furthermore, the dominance of the expert model appears to create a significant barrier in terms of the contribution of boards to strategic decision making. It has emerged that in many trusts the board is only marginally involved as a collective unit in strategic matters given that strategy formulation is left to those who have first hand control of the business activity (Table 3: *3.5.2*). Accordingly, many board members have lamented their difficulty in actively contributing to organizational strategy especially with reference to the possibility of challenging the dominant view of the expert (Table 3: *3.5.1*). This means that the concepts of democratic legitimacy and collaborative ethos are deemed to play a secondary role in strategy formulation as the board generally lacks the necessary power really to influence the direction of the organization. In addition, relying on the discretion of the expert eliminates uncertainty in the short term but also originates a reinforcing circle of expert power in the long run (Table 3: *3.5.4*).

A clear symptom of the dominance of the professional model in strategic decision making is represented by the activity of boards in the presence of critical problems (see Grint 2005) such as when the organization is in financial distress or is facing an equally survival-threatening crisis (collapse of the governance structure, poor quality of the service delivered, chronic inability to meet performance targets, etc.). Consistent with the findings of previous studies (Pettigrew *et al.* 1992; Mueller *et al.* 2004), what we note is that organizational crises can generate enough power to overcome existing relational barriers. That is, in these instances a contingent approach is required due to a limited space/time for collegiality and inclusivity in decision-making processes. Nevertheless, contingent measures cannot represent the general rule of behaviour for boards as they are by definition successful only in specific circumstances.

CONCLUSIONS

The purpose of this study has been to investigate how NHS boards have dealt with the introduction of network-governance principles by the New Labour governments in light of the increased importance of non-bureaucratic and non-market models of co-ordination. The evidence gathered shows that the behavioural dynamics of boards effectively act as antecedents of the implementation of different governance models. Accordingly, the policy makers' design appears to have received mixed implementation

in the sense that only a portion of the board population has effectively incorporated in its modus operandi post-NPM principles of governance.

It has been claimed that boards need to be able to function as a forum for different opinions, to look at all the alternatives available and incorporate multiple (conflicting) factors (Tyge Payne *et al.* 2009). Specifically, NHS boards are required to make decisions in the presence of complex conditions and relationships (e.g. between delivery partners; between prevention and cure). Thus, Finn and Waring (2006) posit that 'architectural knowledge' – the integrated knowledge that results from putting together the specialized and fragmented knowledge of the composing parts of teams/ organizations – plays an essential role in the delivery of effective patient care. The principles of collaboration and partnership in the design and delivery of health care require boards to possess an effective internal dialogue based on the collective contribution of their members. However, many NHS boards appear to struggle to work effectively as a collective.

Our analytical stance suggests that the failure of boards to follow collaborative governance approaches stems from the shortcomings of their behavioural dynamics. For instance, there seems to be an inclination to deal with complex issues by ignoring the complexity of the whole and looking for known and already tested solutions to problems that would necessitate a more holistic and collaborative approach. Essentially, in those boards where the historical model of management within the NHS, the expert model, still exercises a decisive influence, the board's internal dialogue consistently relies on a decision-making process dominated by individuals as other directors without specific expertise find it difficult to challenge the expert position. Moreover, the dominance of the expert model has an impact on how the leadership, monitoring and strategic functions of boards are carried out and, consequently, on the implementation of governance principles.

Our interpretation is that the observed different behavioural dynamics of boards within our sample are fundamentally legitimized by the presence of a hybrid model of governance, which simultaneously allows bureaucratic, market and network principles in the system. NPM styles of boards can thrive as long as they are able to show the ability to hit central targets while 'formally' engaging with the wider stakeholder community, from elected politicians to representatives of the local population and so forth. At the moment, only a handful of core standards are vaguely targeting patient and public involvement and partnership with local authorities (C17 and C22a&c on the Healthcare Commission annual report – Healthcare Commission 2008). One solution could be the establishment of a more direct link between some of the organizational performance indicators and the adoption of collective forms of service design and delivery. Nevertheless, this could generate a formal policy implementation based on the need for trusts of securing funding availability rather than content-relevant application (Bevan and Hood 2006). More importantly, the core of the issue really stays within the realm of the behavioural dynamics of boards and for this there are no immediate answers that can overturn the activities of boards.

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