The intended and unintended outcomes of new governance arrangements within the NHS

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The Report

Executive Summary

Background

The idea of ‘good governance’ has risen to greater prominence in the NHS just as it has in other sectors. The importance of governance has become more apparent not least as a result of various ‘scandals’ in the health services and in the corporate world (RBS, Enron, Mid Staffordshire NHS Foundation Trust etc).

In addition, governance in the NHS is of critical importance because of the policy to move decision-making and governance away from the centre and out to devolved entities (health care providers and commissioners) each with their own self-governing boards.

These forms of devolved governance operate within a complex web of central guidance, national targets, regulators, quasi-markets, and networks. Subtle mixes of collaboration and competition are required in response to (inter alia) payment by results and patient choice.

Aims

In the context of the above, we had a number of interrelated aims. The first of these was to understand more about the underlying logics of key actors at policy levels driving the design of governance arrangements and the overall architecture of governance in and of the NHS. Further, we aimed to find out what sets of governance arrangements were being installed, how they were being operated in practice and how various key participants – executive and non-executive directors, senior clinicians and senior managers - were interpreting and responding to these new governance arrangements. Part of the aim here was to compare and contrast understandings of how the new governance arrangements were supposed to work when viewed from different levels in the NHS (such as national level, SHA level, trust board level and sub-board levels). Another important aim was to probe actors’ reports and evaluations of how governance institutions and arrangements were working in practice.

We also wanted to know what difference different governance arrangements made. To what extent did they matter? Were they treated as ritual or did they influence behaviour and did they have measurable outcomes?
Thus, we aimed to clarify: the forms of governance that were emerging; the sense-making of key actors in relation to governance; changes in behaviour as a result of new governance arrangements; and finally, the impact on organisational performance. These various aims were condensed into four main research questions and were stated in formal terms thus:

1. What do national level system designers intend and expect when they make policy choices affecting organisational forms and governance?

2. How do organisational level managers (chief executives and their teams) interpret and respond to the policy message they receive concerning governance and organisation?

3. What organisation and governance design principles are used by organisation level directors and managers?

4. What perceptions do healthcare staffs have about the new governance arrangements and how are they responding?

About this study

Qualitative and quantitative research methods were deployed. The core of the qualitative research involved 14 case studies of individual trusts: 6 NHS acute/Foundation Trusts, 6 primary care trusts (PCTs) and 2 mental health trusts. These cases were supplemented by interviews with informants from a diverse range of bodies including, the Department of Health, the Treasury, the Cabinet Office, Monitor, the Appointments Commission, the NHS Confederation, Strategic Health Authorities and a series of interviews with chief executives, chairs and directors from a further 15 PCTs and NHS trusts. In total, 197 interviews were conducted.

The quantitative dimension of the research was based on two nationwide postal surveys. The first of these surveyed all executive and non-executive directors of all NHS England acute trusts and Foundation Trusts (except those trusts being researched as case studies). The total population approached numbered 2,051 and we had a response from 579 - a 28.2% response. This was followed with a nationwide survey of all PCT executive and non-executive directors. The total population approached numbered 2,006 with returns made by 669 - a 33.3% response rate. When measured on a trust response basis the response rate was 98.7%.

Key findings

In the report we organise our findings under each of the four main research questions.

As noted, the first of these questions was:

“What do national level system designers intend and expect when they make policy choices affecting organisational forms and governance?” The finding in relation to this question was essentially that redesign of the architecture of governance could prompt and impel a significant shift in the
behaviours of managers, clinicians and other staff. There was an expectation that these actors would be more responsive to local circumstances and would be able to deploy creative solutions if they were surrounded by a series of incentives and regulations alongside central direction and targets. It was further expected and intended that the governance architecture should combine a balanced mix of central guidelines, market and quasi-market challenges, and collaborative and network/partnership arrangements each with their own governance mechanisms.

The second main research question was: “How do organisational level managers (chief executives and their teams) interpret and respond to the policy message they receive concerning governance and organisation?” Here, we found some uncertainty about the meaning and significance of ‘governance’ among organisational actors. Some informants – especially chief executives - judged that they had managed, until recently, with relatively little attention to ‘governance’; and some of them suggested that ‘leadership’ was more important. However, chairs of boards and non-executive directors (NEDs) were champions of the idea and were convinced that it was a vital component of a modern health service.

Crucially, using a composite index of good governance, we found statistically significant evidence to show trust board governance did make a difference. This was most notable with regard to better use of resources. This was a statistically significant finding using a number of statistical tests. Moreover, the survey evidence and the evidence from case studies were in alignment here. As far as we are aware, this is the first time that a reliable finding of the importance of board governance in health services has been established.

The overall architecture of accountabilities of the trust boards to an array of external bodies was perceived as replete with ambiguities, overlaps and gaps. There were uncertainties about the relative reporting obligations to multiple bodies. At times this was conducive to a box-ticking approach.

A further finding at trust board level was that ‘good governance’ was understood by board participants as a balance of forces which enabled the various role-holders to make appropriate inputs. While chief executives were expected to be active and to some degree assertive, the data revealed that where chief executives were perceived by other board members as overly-assertive or domineering, this was judged negatively. That finding was perhaps to be expected. More intriguing was the cross-data set comparisons (questionnaire-derived data compared with independent performance measures). This revealed a statistically significant finding that where scores concerning chief executive assertiveness were high, trust performance measures on a whole range of variables tended to be low. Thus, governance could also once again be shown to make a real difference.

With regard to the third main research question: “What organisation and governance design principles are used by organisation level directors and managers?”, we found that, in the main, most trust boards sought to adopt, and to conform to, standard practice as recommended by Monitor, the
Appointments Commission, and by other regulators. Finding the appropriate balance between market, hierarchy and networks was difficult for many of the actors. Greater influence of PCTs over providers using contracts was in tension with collaborative shaping of clinical pathways. PCTs and acute trusts were still learning about the possibilities for "relational contracting" where parties trade on the basis of strong interdependencies. Hence, we found unresolved tensions between competition and collaboration, and between autonomy and hierarchical direction.

The fourth research question was “What perceptions do healthcare staffs have about the new governance arrangements and how are they responding?” Staff responses to macro-level NHS governance changes were mixed. A substantial proportion of the staff was sceptical of the shifts in governance arrangements. There was suspicion about ‘political’ motives behind many of the changes. Further, there was caution because staff tended to place recent changes in autonomy, accountabilities and governance in a context where certain similar initiatives had been launched in recent decades and then withdrawn or redrawn. At trust level, the main reaction by staff (including senior medics) was to say that they had relatively little knowledge of trust board activity or outcomes. In some trusts their confidence in the trust board and the governors was low. There was a widespread belief that the best that could be expected from trust board governance was good financial stewardship and as little ‘interference’ as possible in clinical matters. But, in contradistinction, we uncovered considerable support and enthusiasm for devolved governance to service lines and clinical business units.

**Conclusions**

The most significant overall finding was that when using a composite measure of ‘good governance’ it was possible to show in a statistically-significant manner that trust board governance can make a positive difference. As noted, this was most especially so with respect to financial and business matters; it was rather less robustly established with regard to clinical outcome measures. This latter finding from the national postal survey was not too surprising when placed in the context of knowledge gained from the detailed case studies. At the present stage of development, most directors – both executive and non executive directors - were far less confident in attending to clinical issues than they were with respect to the use of financial resources. It might be hypothesised that, as trust board governance matures and as the focus increasingly turns to matters of quality and safety, trust board governance may also extends its reach into clinical areas and that positive impacts may in future be measured more clearly.

Another major finding related to the numerous ambiguities and tensions in the modes of governance that have so far been established. The Foundation Trusts revealed most sharply the tensions in governance and accountabilities. These extended outwards to multiple regulators and inwards to internal modes of governance. The complexity of the
accountabilities caused some confusion and a sense of detachment between meaningful governance work and presentational work.

The main supposed substitute for upward accountability was accountability to governors and members. But in many cases, this was found to be weak in practice. This leaves a potentially serious gap.

High profile failures of care suggest that the current accountability mechanisms have sometimes failed to ensure that care quality issues are picked up and addressed by boards, commissioners or regulators.

Such events will place strain on the future viability of the devolved governance model. FTs arguably have no more than a few short years to make this governance model work.
PART 1: POSITIONING THE STUDY

1 Introduction and background

Reforms to the NHS since 2000 in particular have, in varying ways and to varying degrees, shifted the balance of decision-making power, and therefore accountability, away from central government to local NHS organisations (both providers and commissioners), to independent regulators and arm’s length bodies, and to patients and the public. As part of these reforms, the government has created in England new organisations including the semi-autonomous ‘Foundation Trusts’ for acute care and mental health provider organisations, new commissioning bodies (the reconfigured primary care trusts), a new independent regulator (Monitor) for the Foundation Trusts, a new Care Quality Commission and so on. The government has also introduced new mechanisms by which the public can have a stronger voice in shaping the services the NHS provides. These reforms have changed the relationship between central government and the NHS and, in turn, new issues of accountability have arisen. For example, there is some concern that there are too many regulating bodies, that there is lack of clarity about their boundaries, that the lines of accountability are too complex and that, as a consequence, governance has become problematical.

‘Governance’ has emerged within the health service as a very significant requirement and expectation. A new governance architecture and apparatus has been constructed built crucially on ‘unitary boards’ of the ‘trust’ organisations which also variously interlock with boards of Strategic Health Authorities and with the national level government department responsible for health. An important model has been the idea of ‘corporate governance’ as developed over many years in publicly quoted private sector companies. Boards of directors comprising both internal full time executive directors and also external part-time non executive directors have been created at various junctures in the NHS, charged with:

- Setting strategic direction
- Overseeing progress towards the achievement of strategic goals in accord with this direction-setting
- Monitoring performance

The creation of ‘Foundation Trusts’ with semi-autonomous status which frees them from direct control by Strategic Health Authorities sets the stage for a major governance challenge in the form of independent ‘trust boards’.
These kinds of attempts to reform and modernise governance of the NHS are underpinned also by the NHS Constitution published in January 2009.

Further policy changes have been far-reaching in shaping the institutional arrangements of the healthcare landscape in recent years. They include radical changes to financial flows through the ‘payment by results’ (or rather payment by activity) system. They include the ‘choice and personalisation’ agenda which adjusts the demand side of the market place. That ‘market place’ is enhanced further by the promotion of challenge and the increase in potential and actual providers of health services. The split between the provider functions and the commissioning function of the primary care trusts also reinforces this shift.

Supply side policy shifts have included: an intent to create multiple providers; an intent to create some kind of health market with a degree of challenge and competition; devolved autonomy and accountability through Foundation Trust Status and the attendant roles of non executive directors, governors and members.

Demand side policy shifts have included: an attempt to create and allow a measure of user choice; PCTs as assertive commissioners and other changes to commissioning; the specification and enforcement of waiting targets for treatment; regulatory compliance; patient and public voice requirements and a revival of quality as a key measure of success.

In this introductory chapter we first of all describe in more detail the various notions of governance produced by NHS policy makers, bringing out their rationales, as well as the potential challenges, pitfalls and contradictions they pose for those responsible for implementing them. We then summarise the contribution of the literature to understanding these issues. In the light of all this, we elaborate a number of key themes for investigation and describe our overall approach and objectives for empirical research into the realities of NHS governance arrangements and their influence on performance.

1.1 The governance and accountability framework in the NHS

There are some important variations in the governance systems for health in the four constituent countries of the UK. We focused on NHS England. The government minister, Lord Darzi has published an NHS Constitution for England which sets out seven principles that guide the NHS. However, at present the overall governance system responsible for delivering these is complex. It has been argued by the Kings Fund that accountabilities and responsibilities have not been made clear (Dixon 2008). Recent developments include proposals for a new mode of overall governance in the shape of an independent NHS board (Edwards 2007). Representatives from each of the main political parties have put an independent board on the agenda.
The shift from central government control to ‘governance’ has often been seen as a key component of New Labour’s modernisation project. It relates to devolution and to strategic change. Modernisation and governance can be seen as part of a related discourse embracing such ideas as a shift from producer interests to client interests, from uniform standardised services to a demand-led approach activated by the intelligent consumer.

There are different forms of governance regulations cascading down through the reformed structure: directives, standards, assurance frameworks, regulations, incentives, codes of conduct and standing orders. There are also a large number of vehicles for ensuring compliance. There is, in addition, the requirement on Foundation Trusts to develop three-year local delivery plans which address national targets, and on primary care trusts to develop five year strategic commissioning plans to meet the public health needs of their population. Hence, although governance in the NHS is now a highly dispersed phenomenon with a wide array of partnerships and pooled budgets, these all serve to indicate the ‘web of constraints’ within which acute and primary care trusts must function. The complexity presents board members and FT governors with an interesting set of challenges. See Figure 1 for a schematic map of governance in NHS England.

**Figure 1. Overall Map of Governance in NHS England**

![Overall Map of Governance Arrangements in the NHS England](image)

**Key**
- NAO: National Audit Office
- CQC: Care Quality Commission
- SLM: Service Line Management
- LAA: Local Area Agreements
- NPSA: National Patient Safety Agency
- QOF: Quality of Outcomes Framework
At or near the pinnacle of the governance pyramid there is ambiguity concerning the relative powers and responsibilities of the Department of Health, the Cabinet Office, the Prime Minister’s Policy Unit and the Treasury. There is evidence of tensions between the DH and the NHS secretariat in that the latter do not like to see themselves as merely following the politically-driven priorities of the department. Hence, who ultimately ‘governs’ the NHS at the very top is itself a moot point and this explains the intensity of the debate about an independent board (for example, Dixon and Alvarez-Rosete, 2008).

Likewise, the current purpose and role of the reformed ten Strategic Health Authorities is a matter of contention. Essentially they act as arms of the Department. Each has a chief executive, a chair and a board. But the extent to which they simply seek to enforce DH policy or seek to assert a local flavour potentially varies across these bodies. They allocate budgets and they have some discretion to move budgets around if some trusts are in deficit and some in surplus - though in recent times this has become a highly sensitive issue as each trust must, as a priority, be financially robust and failing trusts have turnaround teams sent in to ensure that this is achieved. Senior managers’ jobs – and even chairs of trusts – are at risk if they neglect financial balance. There is ambiguity and uncertainty at this level about the power of the SHA chief executives.

At trust level, overall governance is effected through sets of arrangements based on models borrowed, to a considerable extent, from the corporate world. Extensive guidelines detailing how trust boards should be structured and should behave in order to mimic ‘effective boards’ have been promulgated by the Appointments Commission in conjunction with Monitor and Dr Foster Intelligence (2006a; 2006b; 2007). The guides state the purpose of NHS boards: to set strategic direction, to oversee progress towards strategic goals and to monitor operational performance. In one interpretation these new governance arrangements give very considerable autonomy to FT boards.

At the same time, boards can justifiably claim they are highly constrained. They can point to the array of ‘guidelines’ against which they are inspected and audited. Monitor, the Appointments Commission and the HCC (now CQC) between them variously define the principles which guide how each of the organisations (SHAs, acute trusts and PCTs) should operate. These regulatory bodies also: stipulate the role of the boards, outline the precise information requirements needed by boards, provide model board agendas and suggest an annual cycle of board activities. In addition, SHAs review the performance of PCTs against a series of commissioning competencies. In other words, there is very considerable guidance and thus scope for relatively uniform practice. And given that trusts are overseen and judged by the bodies issuing these guidelines there is considerable incentive to take serious note of their suggestions. Foundation Trusts need to satisfy Monitor that they have in place systems and procedures that meet their criteria.
In addition to the guidance about procedures there are numerous external audits of performance outcomes. Of crucial importance here is the Healthcare Commission (now superseded by the Care Quality Commission). This body has authority to evaluate all trusts’ performance against a detailed list of ‘standards’, which can be understood as organisational competencies, and an annually updated set of performance indicators for different types of trust (acute, primary care, mental health, ambulance) with associated national targets.

At the theoretical axial point to the whole apparatus is the notion of ‘corporate governance’. This denotes the machinery and processes at board level which are designed to allow supervision and policy direction of trust management in primary and secondary care. The intense concentration on trust boards in recent years including, for example, the focus on building ‘effective boards’ is indicative here. Corporate governance is then a phenomenon that sits above and oversees ‘management’. The extent to which initiatives in this area are delivering value for NHS trusts is an important empirical question.

In addition to corporate governance, DH and NHS policy gives considerable weight to other strands of governance activity. ‘Clinical governance’ occurs within the envelope of corporate governance and is to a large degree a tributary of corporate governance. In essence it refers to a series of protocols, institutions and processes which are designed to help ensure that there is some oversight of clinical judgement, practice and outcomes. Individual clinicians and clinical teams are thus held to account. In recent years, trusts have appointed directors of clinical governance and have established clinical governance committees. Whether this is conformance ritual or genuinely useful risk management is a again a question for empirical investigation.

Other aspects of governance concern relationships between different organisational units within the NHS. This strand of governance recognises that healthcare takes place across organisational boundaries. The ability to meet targets at organisational level – in England this means individual trust level - often depends upon effective performance by partner organizations. The World Health Organisation with reference to the governance of patient safety noted that ‘patient safety is at risk when a client is transferred from one structure to another such as from primary care to secondary care or after discharge from a hospital’ (WHO 2005 cited in Bullivant et al 2008 p3). There is plenty of scope for good governance to be circumscribed by organisational boundaries and for governance failure at these boundary points. Likewise, the Healthcare Commission in its learning from investigations (HCC Feb 2008) noted that ‘It is clear that, in relation to service failure, problems often occur at the borders between one organisation or team and another’.

While organisations are becoming increasingly dependent on partnerships and outsourcing this increases reputational risk unless boards are assured that appropriate procedures and controls are in place. The Good Governance Institute has produced a number of toolkits and ‘Board
Assurance Prompts’ to help directors handle this governance challenge. Central to these are a series of key questions that board members should ask about governance between organisations. For example, whether there is continuity of care, whether there has been appropriate identification of strategic partners, whether there has been an adequate assessment of reputational risk, and so on.

New institutions are being created and new forms of accountability devised. These new institutions and forms combine elements of market disciplines with formal direction and control. These diverse modes and combinations of governance mechanisms are generating novel challenges, dilemmas, uncertainties and opportunities. Indeed, many of the elements are still under construction and implementation. Part of the source of the lack of clarity about powers, decision rights and accountabilities is that the apparatus of governance is now extensive, multi-level and interlocking. The very notion of ‘governance’, therefore, eludes a simple and shared definition. The sensemaking work of actors involved in the system thus becomes crucial to its actual realisation in practice (Weick 1995).

Before examining these sense making challenges in more detail, we now fill in a little more detail on recent NHS policy as it affects the conceptualisation of the corporate performance and the specification of corporate governance arrangements intended to oversee it, focusing mainly on the NHS in England.

1.2 The shaping of performance by regulators

There are many regulatory bodies that impact on health organisations. The key ones are the Healthcare Commission (HCC), now merged into the new Care Quality Commission (CQC), who oversee all aspects of service performance, and Monitor, which oversees the performance of Foundation Trusts, focusing particularly on financial and business considerations. The remit and powers of both are established through the Department of Health, although they operate as independent bodies in carrying out their assessment activities.

The policy context for conceptualising the performance of NHS trusts is set out in considerable detail in documents associated with two related DH instruments. These are Standards for Better Health (Department of Health, 2004) and the annual national NHS Operating Framework and the associated guidance for PCTs to follow in producing their annual operational plans and medium term strategic plans (Department of Health, 2008a). These two sets of performance concepts have, in recent years, been brought together by the Healthcare Commission. The HCC was established following publication of Standards for Better Health to carry out an annual survey and assessment of the performance of all NHS trusts throughout England with a view to encouraging continual improvement. The HCC has published guides to its Annual Health Check (Healthcare Commission, 2008), which set out for different kinds of trusts the indicators and processes that will be used to assess and compare their performance, for scrutiny by SHAs in the case of PCTs and non foundation acute trusts, by
Monitor in the case of Foundation Trusts, and for all trusts also by the DH and the public.

Standards for Better Health (Department of Health, 2004) describes seven domains where NHS trusts should be held accountable for achieving certain core standards of competence, and show improvement according to further developmental standards.

The seven domains are:

- Safety
- Clinical and cost effectiveness
- Governance
- Patient focus
- Accessible and responsive care
- Care environment and amenities
- Public Health.

Each of these domains is then broken down into a number of more detailed elements which describe what is to achieve a core or developmental standard within that domain. Trusts are expected to carry out their own self assessment of the extent to which they comply with these standards, to be submitted with relevant evidence to the HCC, who have the right to challenge a trust’s assertions. These standards can therefore be understood as defining performance to be achieved by trusts in terms of activities or processes that must be demonstrated to be undertaken effectively, rather than in terms of outcomes.

The second part of performance assessment in the Annual Health Check is, however, outcomes based. For PCTs, this draws on the same apparatus of performance indicators, know as “vital signs”, that PCTs are expected to use in formulating their annual operational plan for approval by the SHA. For the year May 2008 to April 2009, the DH required PCTs as commissioners to plan for delivery on the following national priorities (Department of Health, 2008a, p. 5):

- Cleanliness and healthcare-associated infections
- Improving access
- Keeping adults and children well, improving their health and reducing health inequalities
- Experience satisfaction and engagement of the public, patients and NHS staff
- Emergency preparedness

PCTs were expected to formulate their plans in terms of different tiers of indicators within the vital signs framework - mandatory national targets, further national priority areas, with a focus on health and wellbeing outcomes in the population, such as the mortality rate from cardiovascular...
disease or cancer in people under the age of 75, the level of obesity in primary school age children, or the percentage of infants breast fed at six to eight weeks. For these indicators, PCTs are supposed to develop their own demanding targets for the year, in the light of factors affecting the current health of the local population, and present these for approval by their SHA, indicating in their plan how they and local providers are going to work together to achieve these targets.

For acute and specialist provider trusts, the second part of the performance assessment in the HCC Annual Health Check is based on a set of indicators related to the Vital Signs framework. For 2008/9, these indicators were also closely related to the five national priorities quoted above, under four headings: health and well-being; clinical quality; patient safety; and patient focus and access. Across these four categories, the indicator set consists of ten existing commitments (e.g. “outpatients waiting longer than the 13 week standard”) and sixteen new national priorities (e.g. “All cancers: one month diagnosis to treatment”). The CQC is developing a new compliance regime based on 16 themes.

We now examine how NHS ideas on corporate governance have evolved as a basis for delivering corporate performance conceptualised in this way.

1.3 Corporate governance in the NHS

Policy makers within the DH emphasise the linkages between corporate governance and the modernisation agenda. In the publication ‘Governing the NHS’ (DH 2003) the connection is made quite explicitly:

“Good governance is an essential springboard for modernisation. Getting it right not only enables staff to do a good job. More critically, it leads to better patient care and enables boards to demonstrate proper accountability to local people for the safe running of the health service”.

This statement places board members and senior managers at the heart of the reforms. It means that accountability is of a higher order than heretofore. Part of the relatively unspoken agenda is the desire to wrest control from doctors, especially hospital consultants, who have long been able to resist the various initiatives such as those stemming from the Griffiths Report (DHSS 1983) which sought to curtail clinicians’ power. Backed by their colleges, individual doctors have largely succeeded in preserving professional autonomy. The notion of ‘management’ within the NHS therefore has been described as more akin to ‘diplomacy’ (Harrison 1999). The more recent changes to governance, with the admixture of plurality of providers, payment by results, clinical audit and clinical governance, greater commissioning powers granted to PCTs, and even further attempts to bolster the power of trust boards and chief executives, may, however, be cumulatively changing this long-standing state of affairs.

In recent times there has been increased attention paid to, and concerns raised about, corporate governance in both the public and private sectors. A series of reports have helped to construct a framework of good practice in corporate governance. In the United States, following high profile corporate
scandals, the US Congress passed the Sarbanes-Oxley Act in 2002. This stipulated that only independent directors could serve on the audit committee and among other things also raised the requirements of financial knowledge among directors. In the UK, the Cadbury Report (1992), the Greenbury Report (1995), Hampel (1998), Turnbull (1999), and Higgs (2003) reports have all contributed to a notion of good board governance. The principles contained in these reports have been brought together in the Combined Code. This has been influential also in shaping public sector governance.

“Governing the NHS” specified NED duties as to constructively challenge and contribute to the development of strategy; to scrutinise the performance of management in meeting goals and standards and monitoring the reporting of performance and service quality; to satisfy themselves that financial information is accurate and that internal systems and controls are robust and defensible; and to ensure that the board acts in the best interests of the public and other stakeholders and is fully accountable for the services provided and the public funds used. It also made strong recommendations as to the number, type and role of board committees which include non-executive directors. The recommendation was that the number of such committees be minimised. Only three are seen as essential:

- An Audit Committee
- A Remuneration Committee
- Nominations Committee (for Foundation Trusts)

Alongside this, the Appointments Commission had been instituted in 2001 and this signalled and drove a new emphasis on the role of non-executive directors. Monitor, the Independent Regulator for NHS Foundation Trusts has also been involved in emphasising, promoting and monitoring good governance.

Progress to date in NHS policy on governance might be claimed in the following areas: clearer definition of the roles and responsibilities of chair, chief executive and non-executive directors; more professional and rigorous recruitment of non-executive directors; more robust internal control systems; clearer requirement for transparency and accountability; the training and development of boards; and regular and systematic reviews of board performance. We now examine the key features of two influential sources of guidance for NHS trusts on such issues: “The Intelligent Board”, published by the Appointments Commission (2006), and the “Integrated Governance Handbook” (Deighan and Bullivant 2006).

1.3.1 The Intelligent Board

“The Intelligent Board” (Appointments Commission 2006: 5) states that the role of NHS boards includes collective responsibility for: adding value to and promoting the success of the organisation; providing leadership for the organisation within a framework of prudent and effective controls; setting strategic direction, ensuring management capacity and capability, and
monitoring and managing performance; safeguarding values and ensuring the organisations obligations to stakeholders are met. The Appointments Commission in conjunction with Dr Foster produced a series of three further documents on ‘The Intelligent Board’, one for acute trust boards, one for SHAs and PCTs and one for mental health boards (Appointments Commission 2006). These have been disseminated throughout the service and are in widespread use by board directors and so it is worth summarising the key points made in these documents.

They argue essentially that ‘effective boards’ depend upon information, thus much of their guidance and advice is about how to ensure that boards have access to the ‘right information at the right time’. The steering group of senior practitioners including the Executive Chairman of Monitor and various chairs and chief executives of NHS trusts, judged that ‘many NHS organisations have some way to go if they are to live up to the challenge of intelligent information that supports and enables effective governance both in terms of oversight and current performance and the setting of strategic direction’ (2003, page 6). No systematic evidence was cited to support this view though one presumes it was based on personal experience across a number of trusts. The report offers a series of recommendations about the kinds of information which boards should seek.

While boards play a key scrutiny role they ‘really add value to their organisations through their strategic role’ (p.7) this requires arrangement of time and appropriate information. As a rule of thumb, the Appointments Commission recommends 60% of time be spent on strategic matters. Strategic information for the board should be structured around an explicit set of strategic goals; show trends in finance and business development; provide forecasts; encourage an external focus. In addition operational performance requires information which: provides an accurate and current picture of recent performance including financial, clinical, regulatory and patient perspectives; be standardised to take account of known factors affecting outcomes such as age and deprivation profiles; focus on the most important issues and highlight exceptions. The document also recommends that ideally all directors (presumably mainly referring to non-executives) should be able to access key information off the premises and between meetings.

Minimum data sets are stipulated as: market and business development (especially important to acute trusts in the context of developments such as patient choice and PBR), directors need to be able to develop the ‘trusts business’ (p.8); key trends and forecasts in relation to finance, resources and HR capacity to deliver, efficiency, patient experience and clinical quality. Foundation Trusts boards also need to take into account the views of their governors and members.

1.3.2 Integrated governance

If the Intelligent Board perspective arose from the provenance of corporate governance as envisaged by Cadbury, Higgs and the rest, so the idea of
‘integrated governance’ arose in the NHS out of the work on clinical governance.

The Integrated Governance Handbook (DH 2006) offers best practice guidelines for executives and non-executive directors in how to promote good governance principles. This was followed in the following year by the booklet ‘Integrated Governance: Delivering Reform on Two and Half Days a Month’ (Deighan, Bullivant and Corbett-Nolan 2007) which was a set of guidelines primarily for NEDs. This body of work has been influential among NHS trusts.

The Integrated Governance Handbook (Deighan & Bullivant, 2006) introduces itself as a source of guidance and support for trust boards in developing their role and governance arrangements in the context of an NHS based on increasingly devolved accountability for performance to corporate boards of trusts. The authors point out that:

‘Devolved accountability offers a board the opportunity to review its purpose and strategic direction in order to realign its structures and supports and so better achieve its goals’ (Deighan & Bullivant, 2006, p. 17)

Four themes in the handbook’s guidance are important for understanding the thinking that has informed NHS policy. First, it emphasises the need for trust boards to take account of a wide range of NHS requirements in determining overall priorities and drawing up annual operational plans for approval by the SHA, but above all the standards for health care provision set out in Standards for Better Health (Department of Health, 2004) and the sets of service indicators and targets updated annually by the Department in its guidance to trusts on formulating annual operational plans. Second, it emphasises the key role of an Assurance Framework that a board should use to complement its identification of strategic priorities during the annual business planning cycle. The Assurance Framework should identify the most important risks to achieving these priorities, how these risks are currently being managed, where there are gaps in risk management controls and assurance and how to remedy these gaps. This should underpin the Statement of Internal Control signed by the CE as part of the statutory annual accounts and report required of all NHS trusts. Third, whilst this assurance system should integrate a wide range of perspectives, including the identification and management of risks in finance, human resources, information systems, and research, at its centre should be clinical governance, a set of practices for identifying risks in and assuring and improving the quality of clinical services. These practices include management systems for monitoring clinical outcomes, clinical risk identification and management, continuing education of clinicians, incorporation of new practices and involvement of clinicians in research and development, and the general “fostering of an ethos of openness and accountability” (Deighan & Bullivant, 2006, p. 35).

Finally, a key message is that this kind of integrated assurance system, based on clinical governance, generally implies a much simplified structure of board committees, with clinical governance in particular embedded within
line management and supervisory responsibilities rather than a parallel quality assurance function executed by a board subcommittee.

The handbook therefore advocates that trusts embark on a process of transition, estimated to take two years, from a common NHS structure where different aspects of quality assurance and risk management are all carried out in isolation by large number of separately constituted board committees. The end point envisaged is a board which takes corporate responsibility for all aspects of strategy setting, performance management and quality assurance, through being satisfied that appropriate systems are in place as part of “business as usual”. Above all, financial management and clinical governance systems are overseen by the whole board, but not actually carried by board members. The Handbook argues that such a board needs only two or three committees: for audit, remuneration and appointments, with the latter two possibly combined. The authors advocate a path for achieving this in terms of first reviewing all committees and subcommittees and then dispensing with those that do not appear to contribute value, and then setting up temporary development committees of the board to design and oversee implementation of performance management and quality assurance systems integrated into line management, for example in clinical governance. This should include advising the board on how performance data should be presented before them, for example in the form of “high level dashboards on clinical activity and variance” (Deighan & Bullivant, 2006, p. 66). Following the completion of their work, the task of reviewing the committee structure and system of reporting to the board should be taken on by the audit committee supported by a corporate or company secretary role.

1.4 Views of governance from the literature

‘Governance’ is a term which is now very widely used in the public services and is by no means confined to health. It has been a key theme in political science in recent years; its rise to prominence is such that it has been described as a “defining narrative” in policy circles (Rhodes, 1997). The ‘governance turn’ has become so pervasive that it has even been suggested that ‘new public governance’ represents the latest paradigm shift displacing the much vaunted ‘New Public Management’ (Osborne 2006). In the NHS, ‘governance’ has been projected to an even more prominent position through a series of policy reforms and reorganisations which have attended to the idea and apparatus of governance in a very explicit way and at multiple levels and in diverse settings. The ideas, principles and mechanisms constituting governance in the NHS derive from an amalgam drawn from corporate governance, public governance and a variety of other sources. The resulting miscellany presents directors, managers and senior clinicians with a considerable sense-making challenge.

Governance in the modern sense tends to be associated with a system constituted by devolved bodies assuming a range of responsibilities while subject to regulations, scrutiny and oversight (Bartle and Vass 2007). It has increasingly been used in the public and voluntary sectors to refer to
the oversight of executive power, it sets the expectations for executive agents, it sets parameters, and it grants decision rights and conditional authority, it monitors performance against targets. The new regulatory bodies created in the UK NHS can indeed be seen as redrawing the nature of governance along such lines (Davies 2007).

Dedicated machinery or apparatus of governance may be established in order to steer, oversee or control the executive function. It has been suggested that the key function of governance is to control and discipline management (Daily and Dalton 2003). This approach accords with agency theory - the dominant perspective that has been used in governance research and theorising. In the context of the NHS it can be extended to also include control over clinicians. From this perspective, governance represents a means to control ‘self-interested behaviour by agents’ (Jensen and Meckling 1976). In the case of the NHS, these ‘agents’ may be variously viewed as managers and clinicians. Depending on circumstances, the part of the controlling principals may be played by directors or by regulators. The senior team acting as a corporate board of directors may enact governance and seek to ensure due diligence as part of its overall set of activities. There can thus be a blurred line with ‘corporate strategy’ and with ‘leadership’. The assumption of the need to control for self-interested behaviour of agents by principals is not shared by all theories of governance. Stewardship theory which works from the assumptions that there can be alignment between intrinsic service motivations and organizational interests offers a significant alternative (Davis, et al. 1997).

Policies and experiments in the realm of governance of the NHS represent then a particular manifestation of a confluence of forces and ideas. In part they reflect a wider trend of the ‘hollowing out of the state’ (Rhodes 1997) across a number of service. In addition they reflect the influence of market ideology and the reform of public service provision. They also reflect responses to widely publicised scandals which prompt a desire to manage risk and reputation as well as a desire to learn from others’ experiences (Benz 2007). Both main political parties have honed a narrative about the NHS which suggests the need for a ‘movement from a “failed” bureaucratic model to a system of entrepreneurial governance that would help it to survive’ (Currie and Brown 2003).

Within this broad view of governance as part of the zeitgeist of the UK public sector, it is possible to use existing literature to conceptualise a number of tensions or contradictions present in the NHS governance arrangements and policies described earlier in this chapter. These are discussed here under five sub-headings:

- Creating public involvement versus state control
- Encouraging competition versus supporting collaboration
- Focussing on “what the board does” versus wider processes
- Creating a paper chase versus critically examining performance
- Towards autonomy versus more tightly drawn constraints
1.4.1 Creating public involvement versus state control

The emergence of new governance arrangements can also be interpreted as response to complexity – a recognition by the state that it needs to share power – a phenomenon that has been described as a shift to ‘co-arrangements’ (Kooiman 2003). This is reinforced by other factors: citizens are better educated and less deferential. They expect to be consulted and be involved. They are ‘challenging bureaucratic or paternalistic modes of administration’ (Clark 2005: 1040). Thus, on an optimistic reading, the changes to governance in the NHS can be interpreted as moves towards more advanced modes of citizenship which reconstitutes clinicians and patients as active participative agents.

There are a number of institutional innovations which might support such a reading. One key objective in reformed governance in the NHS is to increase public involvement in health care governance. The establishment from 2003 onwards of Foundation Trusts with "membership communities" aims to give local citizens a say in management. As Gorsky (2008) has observed, this is not the first attempt to introduce greater community participation in the running of British hospitals. Before the inception of the NHS, the hospital contributory scheme movement provided ordinary members of the public with the opportunity to sit on hospital management boards. Gorsky’s research examined the nature and extent of this earlier experiment with local democracy in hospital governance and it finds that historical precedent is not particularly encouraging, either for the prospect of broadening popular participation or for making services more responsive to local needs. ‘Although today’s context is very different, the tendency for managerial and professional interests to dominate the policy arena is a feature of both periods’.

On the other hand, a less optimistic reading would suggest that the changes reflect the state’s intent to exercise control and influence in more effective and fiscally-affordable ways. To a considerable degree, whatever the initial motive, the course of the outcome will be determined by the behaviour of managers, clinicians and patient representatives within the devolved arrangements. As previous analyses have shown, there is also the element of symbolic behaviour to be taken into account (Freeman and Peck 2007) in its actual performance.

1.4.2 Encouraging competition versus supporting collaboration

On the one hand Foundation Trusts have been urged and encouraged to identify and develop areas of expertise and competitive advantage, on the other there is an expectation that they should not be ‘predatory’ with regard to neighbouring trusts in a way which might render them non-viable. There is an expectation that although competing they should also be cooperating. The same applies vis a vis their relations with the PCT: again there is a dual relationship – this time of contractor and of partner in devising new clinical pathways to the benefit of the population. There is a further contradiction. FTs are supposed to make their own way and, to a certain
extent, be entrepreneurial, but they operate within a set of constraints which make it difficult to withdraw from service offerings – including those revealed as loss making. One source of pressure impels trusts towards autonomy and the competitive model of customers, strategies, marketing and market share. An alternative pressure is the statutory duty on the Foundation Trusts, under the terms of their authorization to cooperate with other parts of the healthcare community. This is reinforced by occasional messages from the NHS Chief Executive concerning the ‘one NHS’. A third source of pressure holds both acute and primary care trusts accountable for the delivery of centrally-directed targets and diktats.

The new NHS puts PCTs potentially under equivalent contradictory pressures. NHS policy appears to encourage PCTs on the one hand to support existing acute providers and help them develop more effective and relevant services. At the same time it may well be encouraging PCTs as commissioners to grow the provider side of the market by favouring private sector providers or new social enterprises.

1.4.3 Focussing on “what the board does” versus wider processes

In one widely used sense governance appears to hinge around ‘what the board does’. This has been elaborated by the Appointments Commission and Dr Foster in their ‘Intelligent Board’ series of guides. This implies a relatively small number of actors. However, other players in the system seem to interpret governance as an organization-wide web of responsibilities running down through clinical services to ward and clinic level (“board to ward”) and implicating a cast of hundreds. Foundation Trust governance arrangements involve the recruitment of members and the election and appointment of governors, who are also expected to influence strategic and other executive management decisions. Consequently, the relationships between executive directors, non-executive directors, governors, clinical leads, and general managers, and their opposite numbers in ‘partner’ organizations (for example, PCTs and ambulance trusts) and of course the multiple regulators, have become significantly more complex.

1.4.4 Creating a paper chase versus critically examining performance

The Audit Commission Report (2009) “Taking it on Trust” published in April 2009 examined the rigour with which NHS trust boards operate the processes available to them and get the assurance they need. The study noted discrepancies between trust declarations of compliance with Standards for Better Health and subsequent Healthcare Commission inspections; differences between statements on internal control (SICs) and core standards declarations; and some major failures in patient care, such as that at Maidstone and Tunbridge Wells NHS Trust and Mid Staffordshire NHS Foundation Trust. All have revealed significant gaps between the processes on paper and the rigour with which they are applied. The report
said that the introduction of FTs has generally reinvigorated governance processes and resulted in the recruitment of non-executives with a greater knowledge of effective risk management and board challenge drawn from private sector experience. However, there was room for much improvement. In the worst cases, the assurance process had become ‘a paper chase’ rather than a critical examination of the effectiveness of the trust’s internal controls and risk management arrangements.

1.4.5 Towards autonomy versus more tightly drawn constraints

We have earlier described a whole series of organisational changes relating to governance which have been initiated in NHS England. Some of the changes suggest a mode of devolved governance which grants considerable autonomy to those trusts with the courage and the initiative to exploit it. Other changes and other interpretations however suggest that what is happening is the construction of a more complicated and intricate web of controls.

The main elements are shown in summary form in Table 1.

Table 1. Governance changes in NHS England – towards freedom or control?

<table>
<thead>
<tr>
<th>Indicators of autonomy</th>
<th>Indicators of control</th>
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<tr>
<td>Foundation Trust status</td>
<td>Signs of continued attempts at direction from DH</td>
</tr>
<tr>
<td>Appointments Commission raises credibility and competences of trust boards</td>
<td>Appointments Commission takes recruitment &amp; selection away from trusts</td>
</tr>
<tr>
<td>Stronger link to community via governors and members</td>
<td>Governors and members of FTs often ineffectual; purchasing/commissioning power resides with PCTs which have no similar representative structure</td>
</tr>
<tr>
<td>Local boards accountable to local people</td>
<td>Local accountability is limited; Oversight &amp; Scrutiny Committee procedures cover exceptional cases; service provision is planned away from localities</td>
</tr>
<tr>
<td>More powerful tools for boards</td>
<td>Boards have to respond above all to intensive regulation, inspection and audit from HCC and Monitor</td>
</tr>
<tr>
<td>Reduced size of the DH</td>
<td>Political influence remains</td>
</tr>
<tr>
<td>Reduced size of the SHAs</td>
<td>Some SHAs maintain an approach which embraces FTs as well as PCTs</td>
</tr>
<tr>
<td>Money following the patient</td>
<td>Central targets- eg 4 hour A&amp;A; 18 week wait from referral to treatment</td>
</tr>
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Drawing on the table we first pull together the signs of devolved power and then we consider the case which suggests more control. We then proceed to consider other interpretations.
Perhaps the clearest expression of the devolved model is the creation of the Foundation Trusts. For the first 60 years of the existence of the NHS central government was held responsible for almost all aspects of the operation of hospitals. With the new Foundation Trust governance arrangements this was supposed to change fundamentally. The accountability structure for Foundation Trusts is clear: their boards are accountable to their governors and, in turn, to local citizens through membership structures. This structure could suggest a basis for legitimacy which is rooted in the locality rather than from the centre.

The next necessary element is capability. The creation of the Appointments Commission was designed to ensure that persons appointed to non-executive directorships are of a high calibre. A further element is access to appropriate tools. A crucial accompaniment to the creation of Trust status has been a conscious attempt to build-in more sophisticated and formal governance machinery – board protocols, risk registers, annual calendars, clarification of roles and so on. Also, and crucially, much more information has been made available to trust boards. They have access to performance scorecards and comparative data. Extra information is provided by the Audit Commission, the Healthcare Commission, by Dr Foster and Monitor. Trust boards can see very clearly how their institution is performing across a whole array of measures – including if required the relative performance of individual service lines and even individual doctors.

Trust boards are explicitly expected to adopt a ‘business-like’ approach and to devise their own strategies. The NHS is supposed to be moving away from a ‘provider driven’ service to one which welcomes and enables patient choice. As a result of this new framework, trusts are expected to focus on ‘market and business development in the context of patient choice and payment by results, boards increasingly need to think in terms of understanding their markets, analysing the competition and developing the trusts business’ (Appointments Commission 2006 : 8).

Expressions of intended devolved accountability might be perceived as hollow if the size and capacity of the centre remained stable or was to grow. In fact, along with other Whitehall departments, the Department of Health has reduced its workforce size substantially along with its regional arms the SHAs. Despite this, questions about the meaningfulness of the assertion by Chief Executive of the NHS, David Nicholson, that trusts should ‘look outwards not upwards’ remain.

Finally, the financial regime based on the principle of money following the patient – in reality a system of payment for activity means that instead of centrally-directed or even regionally directed allocation of funding, Foundation Trusts can compete and grow if they can offer cost effective services in settings which patients and commissioners wish to buy-into. To this extent, the destiny of the trusts is in their own hands.

The intended consequences are trust autonomy, management freedom, patient and public involvement, care tailored to local community needs and preferences, doctors closely engaged in the strategy and management of their employing trusts. This at least is the optimistic scenario.
An alternative interpretation of the new governance arrangements can be made. Despite the elements of devolved powers and responsibilities, there are signs that the centre continues to exercise influence in many very significant ways.

Centrally-determined targets and priorities are prominent in the annual planning guidance issued to PCTs as well as for acute trusts. The annual Department of Health’s ‘Operating Framework’ stipulates the priorities of central government demands from the NHS. Thus, while nominally PCTs as commissioners holding three-quarters of the NHS budget have been encouraged to act according to their interpretation of local needs, in practice they must also meet these central priorities. The 2008-9 Operating Framework stipulates a number of key priorities: reducing healthcare associated infections; reducing waiting times; reducing health inequalities; improving access to GP services in the evenings and at weekends. There are also policy goals from previous years. The Operating Framework sets out the principles of competition and cooperation; in large measure trusts have responded to the new governance arrangements in similar ways.

The power of the HC to inspect both hospital trusts and PCTs ensures that it too plays a part in governance in the sense that it wields delegated powers from Parliament to set standards and to ensure compliance with standards. They can, and do, set new priorities for trust boards. An example of just such a recent shift in priority is the way the Healthcare Commission’s blueprint for the annual health check 2008-09 has stipulated that primary care trusts will be assessed on the quality of commissioning. This follows criticism of PCTs’ commissioning skills. The Chief Executive of the HCC has stated that: "The commission wants the assessment to be more focused on clinical quality" Under the plans, trust boards will have to declare whether they have complied with the 24 national core standards for their commissioning and providing functions.

Overall, then, the Department of Health continues to issue instructions and to set priorities. This was always understood to be possible via the PCT commissioners – i.e. from the DH to the SHAs and on to the primary care trusts as commissioners. But despite Foundation Trust status, instructions and directives continue to be issued even for the supposedly autonomous Foundation Trusts. This is a controversial and as yet unresolved area. One example relates to the way the Chief Executive of the NHS issued instructions to all hospitals concerning procedures for hygiene such as instructions to ‘deep-clean’ wards and to give stronger power to matrons. In reaction to this the Chief Executive of Monitor, protested that this was a de facto attempt to erode the independence of Foundation Trusts (Carvel 2008: 2).

1.5 Literature on governance and performance

Having examined the tensions and contradictions present in NHS thinking and policy and governance, we now turn to the literature on the relationship between governance arrangements and organisational performance. One of the premises at the heart of the call for proposals giving rise to this
research – that organizational forms might be presumed to have a series of impacts on behaviours and performance outcomes - is one which has long been argued about in the core areas of organisational analysis and industrial sociology. Contemporary discussions in health services research reflect long-standing debates in the classic literature on organisational strategy and design (Lawrence and Lorsch 1967; Child 1972; Pugh and Hickson 1976). For example, Idema, Meyerkert et al. 2005 in the Health Service Management Research Journal claim that in the turbulent context of complexity, fragmentation and change in health services, the organic forms of teams, participative modes, self-organisation and flexibility are the appropriate forms. Much similar work is steeped in the positivist tradition. But Ferlie’s assessment indicates the limitations of much of the work in this tradition (Ferlie and Aggarwal 2002; Ferlie and Addicote 2004). Our intent in designing our approach to this project was to move from ‘variance explanation’ to ‘process explanation’ (Langley 1999).

A number of pieces of research in health services as well as of course in other sectors point to the limited explanatory power of structural factors alone. For example, in a recent study of Integrated Primary Care Organisations (IPCOs) it was found that important measures such as the level of productivity and transaction costs were not significantly related to structural aspects such as the size of these IPCOs; rather, the attitudes and orientations of health care workers was found to be more important. (Simoens and Scott 2005). In response to this we tried to give more attention to contextual, processual, temporal and political issues. While there has been a preoccupation with structures and incentives in government policy, these wider issues tend to be neglected. And the socially constructed nature of ‘performance’ is also often overlooked. Thus, in place of the oversimplified focus on ‘structures-and-rewards’ we used a process-based perspective (Pettigrew, Ferlie et al. 1992; Poole, Van de Ven et al. 2000; Dawson 2003). Considerable work has already been done on the implications of the measurement of performance and outcomes. For example, it is suggested that the now numerous performance indicators (PIs), league tables, targets, star systems, and their associated penalties and rewards are often counterproductive. The reasoning is that if these indicators are used for evaluative judgements rather than for purposes of learning and development then they can induce ‘perverse incentives’ (Mullen 2004). This argument of course rests largely on how the actors interpret the system of messages which surround them and how other significant actors give priority to some of these messages and not others. The current pattern of individual, often idiosyncratic, expressions of meaning by those involved requires more systematic investigation of their meaning systems (Cundy 2002; Cortvriend 2004). A further question is the dual roles of clinicians as managed and managers (Locock, et al. 2004).

A great deal of the literature relevant to understanding the relationship between governance and performance in healthcare has already been reviewed in three separate systematic literature reviews funded by the SDO (Sheaff et al 2005; Davies et al 2005; and Peckham, et al. 2005). Members of the current research team contributed to the Davies et al review and, in
the light of the ready availability of that report and of the other two reports it is not necessary to repeat that work here. Instead, we provide a brief summary of relevant points.

In their review of the potential link between ‘organisational factors and performance’ Sheaff, et al. (2005) note that while policy makers have long assumed that structural and procedural changes are levers for improving health care performance, there is limited evidence to support this. Following their analysis of 1,568 references that met their inclusion criteria, they found that there are few, if any, levers that directly influence organisational performance nor any strong and consistent relationships between organisational ownership, contractual arrangements and performance. But they also state that there is some evidence that different organisational structures appear to be associated with different kinds of outcome. Their NHS consultations revealed that decision makers were in any case inclined towards favouring a move away from professional silos and more towards functionally-based structures. The literature review reflected the widely-held view that unstable environments are best matched with organic, matrix, structures. These at least are the implications arising from positivistic research methods. The key research gap appears to be the nature and extent of the linkages between new organisational forms in the NHS and the wide range of different performance outcomes desired in this sector. Below we will describe how we propose to overcome these problems.

In the widest of the SDO literature reviews (Davies et al 2005) an assessment was made of ‘the incentive effects of different forms of governance of health care organisations’. This report explored the Governance-Incentives-Outcomes model. The notion of ‘governance’ was interpreted as different combinations of markets, hierarchies and networks. A distinctive feature of this review was the initial discipline-based structuring of the review which enabled, for example, often very influential assumptions and approaches from the economics perspective on governance and incentives to be unpicked. The multiple and mixed modes of governance – for example markets within hierarchies are noted. But, echoing the study by Sheaff et al (2004) the limited evidence for direct incentive effects deriving from particular organisational forms was again identified.

The report by Peckham, et al. (2005) had a narrower focus than either of the above in that it seeks to assess one type of ‘solution’ (decentralisation). As they note, the assumption, in the main, is that decentralisation is positive because it enables and promotes responsiveness to local needs, allows de-layering, empowers staff, promotes accountability and prompts managers to manage. On the other hand, they find that in practice there is far less clarity about what is decentralised and there is muddle about key concepts such as authority, accountability and responsibility. There is, in sum, lack of certainty about the direction and nature of the movement (often centralisation accompanies decentralisation) and there is even more uncertainty about the impact on performance. They conclude that the ‘key message’ from their review of the literature on decentralisation is that it is ‘not a sufficiently strong individual factor to influence organisational
performance as compared to other factors such as organisational culture, external environment, performance monitoring etc’ (2005:9). Peckham et al contend therefore that policy makers and practitioners frequently base decisions about decentralisation on assumptions which are not supported by theory or evidence. We agree with this conclusion and we suggest that the key research need now is to investigate the interpretative schemas of the key decision makers at each level – these are the actors who give meaning to the otherwise imprecise concepts.

So, taking the three scoping studies together, it was evident that governance and incentive arrangements continued to fascinate policy makers, practitioners and academic analysts. But, it was equally evident from all three meta-studies that while these notions shape decision makers’ thinking and actions, the evidence for assuming such clear connections was markedly lacking. The overall conclusion is simply that in shaping the impact of changes to NHS governance arrangements much will depend upon how the various actors in the system make sense of the new freedoms and new imperatives. There are very few if any foregone conclusions to be made simply on the basis of the new arrangement.

Building on this summary of the literature and linking it to the earlier discussion of policy papers relevant to governance, we can note that a key theme and tension in relation to governance is the question of accountability. As we have seen, accountability in the reformed NHS runs in multiple directions. As a way to simplify these multiple lines of accountability it is useful to view them as mainly running in three directions: vertically, horizontally and diagonally. Table 2 below shows an overall schematic view. We will elaborate this during the reporting of the detailed findings from the study.

| Table 2. Summary of types of accountability of NHS bodies |
|-------------------------------|-------------------------------|-------------------------------|
| Definition | Foundation Trusts | PCTs SHAs |
| **Vertical** | Agent is not ‘independent’ from the forum | Parliament, Board of Governors Monitor | SHA, Secretary of State for Health /Department of Health |
| | The forum is hierarchically superior to the agent | | Secretary of State for Health/Department of Health |
| | The forum has sanctioning powers | | |
| | Actors must provide the requested information | | |
**Diagonal**  
Agent is ‘independent’ from the forum  
The forum is not hierarchically superior to the agent  
The forum is independent from the principal, but has been granted powers by the principal to conduct assessment of the actor’s performance.  
The forum does not necessarily have sanctioning powers, but there can be potential consequences as the forum can refer the case to the principal

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<th>Monitor CQC</th>
<th>CQC Audit Commission</th>
<th>Audit Commission</th>
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Based on Schillemans (2007); and Dixon, Storey and Alvarez Rosete (2010/forthcoming)

The purpose of presenting this table at this stage is simply to illustrate, in a very succinct manner, the key institutions and the lines of accountability running between them. The nature of these linkages and how they are perceived and acted upon by the participants in the system are reported in the findings section of this report.

1.6 The focus of our study

We have set out to approach the issues in a new way – or rather a combination of ways. We wanted to give much greater prominence to the theories of the actors themselves. An important aspect concerning how governance might affect performance is to probe the thinking of those managers and organisational designers who construct or aspire to construct new forms or amendments to forms. Their thinking, assumptions and priorities about potential causal connections carry important consequences.

A related aspect is how those actors on the receiving end of governance structures and organisational forms interpret and take account of these arrangements and ‘messages’. How, and to what extent do they respond to the messages implied in the forms of governance? Crucially, what priority do they accord these messages alongside the many other messages in their organisational worlds? We did not conceive of this process within the confines of a ‘transmitters and receivers model’ (Shannon and Weaver 1949) - reality is more nuanced. The types of ‘guidelines’ issued from the centre within the NHS require considerable interpretation and one finds significant variation in the interpretations made and actions taken. Likewise, some ‘directives’ are virtually ignored in practice as a result of competing local priorities. Indeed, the merit of our approach is that it is especially alert to these aspects of organisational behaviour. We pay close attention to the sense-making behaviour of the actors.

The research aim and focus therefore, was to discover both the espoused theories and the theories-in-use of those key actors responsible for translating policy into governance and organizational arrangements. Key research questions included: How do key decision-makers develop and construct assumptions and theories of the link between governance and organizational structure, process and performance? How do those theories translate into the organizational forms and processes that characterise healthcare? How do decision makers understand the links between policy, incentives, organizational forms, and the outcomes that those incentives
and organizational structures are designed to achieve? How do healthcare professionals interpret the nature and implications of the different organisational forms? To what extent are their theories supported by the ‘hard evidence’ of quantitative performance measures?

The research domain, the types of organisation to be researched, the location and the units of analysis ranged across each of the levels specified in the original OP110 bid call. The core theme of the inquiry – the links between governance and incentive arrangements and the behaviour and performance of healthcare professionals and healthcare organisations – we judged would benefit immensely from an integrated, cross-level analysis which compared the interpretative schemas of key actors occupying positions within each of these layers. A key feature of the research we undertook resided in its attempt to integrate the investigation across levels and types of organisations. This we believe is highly germane to the essential nature of the core problematic that was posed in the original bid call.

1.6.1 Scope and key themes

We tried to address the key aspects of the original OP110 project Call. Hence, our work was designed to answer the big questions relating to the relationships between governance, organisational forms, incentives and performance. We took a holistic and integrative view: we operated, as promised, at multiple levels of the health service from the highest policy levels in the Department of Health and down through the national regulatory bodies, the Strategic Health Authorities, the primary care trusts, the acute trusts and mental health trusts and down further into the directorate levels of the trusts. We present findings from our work in primary care trusts, acute trusts and, to a lesser extent, mental health trusts. Primary care trusts are of interest and relevance because they are varied and are still defining their internal roles and structures, as well as their external partnership and other collaborative relationships. These features rendered them as appropriate locations for a study of management decisions about incentives, structures, and performance. The acute trusts are interesting and relevant because they are complex and multi-faceted and the issues of form, governance and performance are of huge importance. In other words, the research reached across multiple levels – individuals, organisational and the NHS-system level. Mental health trusts are interesting because in some respects they offer a direct comparison with other provider trusts (and they often copy board governance structures and practices directly from acute FTs) and yet they face their own distinct challenges. We show findings which reveal the importance and impact of the differences.

We also addressed multiple aspects of form, governance and consequences. We gave heavy emphasis to the ways in which the key actors – at multiple levels – themselves made sense of the forces and factors in play. We probed, in particular, how key decision-makers constructed their own theories and assumptions about the linkages between organisational form/governance, behavioural implications and performance outcomes. We
tried to surface and understand the KPIs to which they themselves give priority.

This was further supplemented by a ‘hard-measures’ approach to a much wider array of performance measures in order to provide an additional check on outcomes both intended and unintended. The so-called ‘perverse’ effects of targets make new sense when approached from an actor-theory perspective. The hard measure methodology was pursued through a nation-wide survey of all board directors – executive and non executive in all primary care trusts and all acute trusts – both Foundation Trust status and those without.

The research design thus will allow multiple comparisons of perspectives, assumptions and theorising across multiple levels while at the same time allowing these comparisons to be assessed against a backcloth of multiple measures.

1.7 Summary of key research questions

We set out to answer the following key research questions:

1. What do national level system designers intend and expect when they make policy choices affecting organisational forms and governance?

2. How do organisational level managers (chief executives and their teams) interpret and respond to the policy message they receive concerning governance and organisation?

3. What organisation and governance design principles are used by organisation level directors and managers?

4. What perceptions do healthcare staffs have about the new governance arrangements and how are they responding?

Thus, the research aimed to examine the intended and unintended outcomes of the range of governance and incentive devices deployed within the NHS.
2 Project design and methodology

The approach adopted in this research combined qualitative and quantitative methods, direct observation and the examination of documentation. Each of these methods were cross-compared and interlinked where possible.

2.1 Qualitative research

Using semi-structured interview schedules, we interviewed key informants at all relevant key levels of the NHS – from national policy level, SHA level, trust level and down to the distributed governance level of clinical business units within Foundation Trusts. Cases were selected based on a achieving a reasonable spread across the country with acute and primary care trust cases in London, the south, midlands and north of England. It was not always possible to match-up PCTs and acute trusts as parts of the same health economy. In some respects, while coterminous cases were not always possible we found this was not a significant problem and that on the contrary this allowed some wider coverage and exposure to a wider variety of practices. The implications arising from findings from one set of cases were used to inform the dynamics and emergent modes of questioning in the other cases. The pattern of repeat interviews used in the research design was especially valuable because of this research technique.

Each interview lasted between one to two hours. Key informants – those with profound insights were interviewed on two and even three occasions. The interviews were recorded using the latest digital recorders and they were then professionally transcribed verbatim. The transcripts were analysed by different members of the research team and consensus was sought concerning their meaning and their contribution. Through comparative work among team members, selections were made about which segments of transcripts would be used in order to illustrate perspectives in this report. For the design, conduct and compositional phases of the case study reporting we drew heavily on guidance from Yin (2008). We adopted two of Yin’s strategies for qualitative data analysis. First, we produced individual rich case descriptions based on multiple interview transcripts from the same case site. These accounts of the ‘case story’ were shared between the course team. Second, we simultaneously proceeded to use the data to explore and test theoretical propositions about governance (for example, that chair’s of trusts would be more supportive of board governance in general than chief executives).

In the following paragraphs we describe the sequence of activity in the conduct of the qualitative part of the study.
The qualitative research involved an initial series of interviews with a wide selection of informants at all main levels of the NHS. This phase of the interview programme began with a series of interviews at the Department of Health and related agencies of central government including the Cabinet Office and the Treasury. These interviews served to build a picture of policy intent among various central players. The next phase involved a series of interviews with key agencies and regulators such as Monitor, the Healthcare Commission, and the Appointments Commission. The purpose of these interviews was to clarify how these key agencies interpreted the framework of governance and their own roles within it. A total of 12 interviews took place at this first stage of the research.

The next stage was research at the Strategic Health Authority level. Work began at the Office of the SHAs and then worked outwards. Chief executives and chairs from three of the ten SHAs were interviewed. In addition, interviews were conducted with non-executive directors of the SHAs. The purpose of this phase of the research was to understand how players at the SHA level interpreted their own role in NHS governance and this included governance through boards at SHA level as well as their interpretations of how they could and should seek to involve themselves in governance of the trusts in their territories. A total of 10 interviews took place during this phase.

The next stage of the qualitative research took place at PCT and NHS trust level. This work began with a series of selected interviews across 12 PCTs and 12 NHS trusts/FTs. These were ‘dip-stick’ interviews with a random sample of chairs, chief executives, medical directors, non-executive directors and a series of executive directors – especially those with a special responsibility for governance. The purpose of this phase was to gather broad intelligence about the kinds of issues and tensions associated with governance at trust level. A total of 36 interviews took place at this stage.

The next main stage of the qualitative research was in a sense the core part of the study. This involved detailed case studies of six PCTs and six acute trusts (four of which were Foundation Trusts) and two mental health trusts – one of which was an FT and the other was close to applying for FT status. In these 14 cases, the research involved interviews with all members of the trust boards, with governors when the case study was of an FT, and with a selection of senior clinicians – mainly clinical directors and, in the case of PCTs, members of PECs. Interviews were also conducted with senior clinical staff. In a selection of these cases the work also involved direct observation of trust boards in action and of meetings of the governors. The purpose of this main phase of the project was to delve deeply in to the range of issues and the range of meanings which the core actors brought to bear on the work of governance. A total of 140 interviews took place at this stage of the research.
2.2 Quantitative research – the national postal surveys

About half way through the core case study phase, the knowledge gained about the core issues and tensions was used to construct a number of postal questionnaires. One instrument was designed for all board members of Foundation Trusts, another closely related version was designed for board members of NHS acute trusts which were not FTs, and a third questionnaire was designed for board members of PCTs. This survey work took place in parallel with the latter half of the case study work. Copies of the questionnaires are shown in the Appendix to this report.

Questionnaires were posted in personally-addressed envelopes to a database of all board directors of acute trusts and PCTs which we had constructed in early 2008. A total of 2,051 questionnaires were sent out to acute trusts and 579 usable returns were received – a response rate of 28.2%. Additionally, a total of 2,006 questionnaires were posted to board members of PCTs and 669 usable returns were received – a response rate of 33.3%. As we were approaching all directors in these trusts (including chairs and chief executives) the result was that we almost invariably received some response from every trust. Hence, when measured as a response rate on a trust basis a 98.7% response rate was achieved. We thus gathered information about trust governance from virtually every primary care and every acute trust in England.

The questionnaires were designed to reveal the comparative interpretations of different board members to the meaning of governance in these trusts, the actual workings of governance, the problems and the successes and the perceived impact on performance outcomes of various kinds. The research team meanwhile had trawled though the variety of available sources of data on the performance indicators for all trusts in England. A database was constructed which consolidated selected indices including, for example, patient and staff satisfaction and attitudes, mortality rates, length of stay, infection rates and the results of the assessments made by the HCC on a range of performance indicators.

We thus built up two separate databases containing information about all PCTs and all NHS trusts and FTs in the country (with the exception of some of the case study sites where we did not want to burden our respondents with too many requests). One database contained unique responses to a whole series of questions about governance structures and governance processes. The other database which was derived from multiple published sources contained data about performance of these same trusts. We then brought these two databases together into one merged file. This allowed a whole series of statistical test to be undertaken which uniquely enabled a direct comparison between governance and performance.

In our analysis of the results, two main levels of analysis were made - individual level and trust level analyses. Thus, we can make generalisations about overall patterns and trends as reported by all trust directors and we can also focus-in on specific trusts in order to look for context-specific
patterns. These two levels of analysis were used for both the Acute and the Primary Care National Postal Surveys. In addition, as we collected respondents’ job titles and responsibilities we were also able to relate assessments about various governance practices to position.

In the report on the findings below, bivariate and also multivariate (factor analysis) are deployed.

2.3 Research ethics

The study was conducted using the framework and protocols of COREC. The methods of the study and the associated instruments were submitted for ethical approval to an MREC for multi-site authorisation across the NHS. In addition, for certain aspects of the study, site by site approval was also sought from local research ethics committees (LRECS). Interviewees were given, in advance of an interview, a Participant Information Sheet and an accompanying Research Participant Consent Form. The Participant Information Sheet described the purpose and nature of the study. It also described who was conducting the study and it gave contact details of the academic researchers and the local, on-site, point of contact. Most importantly, the information sheet assured the interviewee of confidentiality and it explained the meaning and implications of that assurance. The information sheet also made clear that participants in the research could withdraw from the process at any time and without any consequences and that other persons would not be informed of such a move. The information sheet also described how the interview would be recorded and what steps would be taken to safeguard that recording. This document also made clear that care would be taken to ensure that it was not possible to associate a quotation from a particular interview transcript to be traced to an identifiable site still less to any particular individual. It was noted that all sites would be anonymised. Interviewees were also given a ‘topic guide’ in advance so that they were aware what kinds of issues were to be discussed - though they were not given the precise questions.

Interviewees were not offered editorial rights over the resulting transcripts. However, if a respondent did request a copy of the transcript of the interview, that was made available to them.

The Research Participant Consent Form gave a summary of the key points of the interview process to which a potential interviewee was about to engage and this form also made clear that if consent was given then the form should be signed and dated. This form was also signed and dated by the interviewer and the document became a ‘contract’ between the parties.
PART 2: THE FINDINGS OF THE STUDY

This part of the report contains four chapters which present and discuss findings at the various levels of governance. Chapter 3 presents findings at the national level (central government and government departments), and the findings about the influence of the Regulators and the Strategic Health Authorities. Chapter 4 presents findings about the PCTs, Chapter 5 presents the findings from the study of NHS acute trusts (including Foundation Trusts). Chapter 6 presents the findings from mental health trusts.

3 Findings at national policy level, SHAs and regulators

In this section we seek to find answers to the research question most relevant to this level:

**What do national-level system designers intend and expect when they make policy choices affecting organisational forms and governance?**

The research aimed to examine the intended and unintended outcomes of the range of governance and incentive devices deployed within the NHS. It seemed sensible to begin with the intentions and the design principles.

The shift from central government control to ‘governance’ was a key component of New Labour’s modernisation project. It related to devolution and to strategic change. Modernisation and governance can be seen as part of a related discourse embracing such ideas as a shift from producer interests to client interests, from uniform standardised services to a demand-led approach activated by the intelligent consumer.

Running alongside the general policy of devolved governance to local boards is the continued emphasis on centrally-led targets and mandated polices. And some of these have produced commendable results. For example, NHS in England officially hit its target to treat patients within a maximum of 18 weeks from referral by their GP in March 2009. The Department of Health reported (DH March 2009) that the average wait for treatment for admitted patients came down to 8.6 weeks. This pattern of maintaining both central-drive and local accountability can be seen as part of the complex pattern of governance.

In the following sub-sections we discuss findings from the national policy level, then the national level regulators, then the findings from our research in Strategic Health Authorities.
3.1.1 National level governance policy makers

Policy makers within the UK Department of Health (DH) make an explicit linkage between ‘governance’ and the ‘modernisation agenda’. In the publication ‘Governing the NHS’ (DH 2003) the connection is spelled out as follows:

“Good governance is an essential springboard for modernisation. Getting it right not only enables staff to do a good job. More critically, it leads to better patient care and enables boards to demonstrate proper accountability to local people for the safe running of the health service”.

This statement places board members and senior managers of local primary care and acute care organisations at the heart of the reforms.

Policy construction and advice at the apex we found was provided by multiple sources – for example, apart from the NHS Chief Executive (David Nicholson) there were various DH ministers and policy advisers. In addition, policy on the NHS was also emerging from the Treasury, the Cabinet Office and the Prime Minister’s Policy Development Unit. NHS England under Nicholson also contained the NHS Management Board which included the chief executives of the ten strategic health authorities plus the Permanent Secretary and his team. There were also people in the NHS who were said to work directly for the Chief Executive ‘as opposed to the DoH’. When Nigel Crisp was in post the role of the Permanent Secretary of the Department of Health and the Chief Executive of the NHS were merged. At the time of our research (2007/2008) they had been de-merged. In governance terms, this meant that there were a team of people who worked for him, ‘as opposed to working for ministers’. In the light of these multiple forces it is hardly surprising that policy developments often appeared less than uniform.

Various attempts were said to have been made to overcome these problems. The relationship between the Department of Health and the NHS in the 1990s was assessed by Day and Klein (2000). More recent attempts to clarify the nature of the relations between the NHS and Whitehall can be found discussed in Greer and Jarman (2007) and aspects of changes in health policy related to institutional arrangements can also be found in Greener (2008); Greener 2009); Gabe and Calnan (eds) (2009); Harrison and McDonald (2007) and Hunter (2008). Greer and Jarman’s (2007) findings concerning the strong managerial ethos within the Department of Health and the influence exercised by management consultants, echo our own findings.

In our work at DH level we found emphasis being placed on the introduction of Gateway, the Chief Executive’s letter relating to Foundation Trusts and the importance of briefings to the SHAs in order to coordinate and prioritise messages and requirements of the service. Also, the de-merger of the DH/NHS Executive was designed so that the DH part looked inwards to service the Minister, while the NHS Executive faced outward through the SHAs to the service itself. It was claimed that the shift from ‘guidance’ to ‘sharing better practice’ supports the move from the mother-ship idea. In 2007 during the early phase of our research the Cabinet Office undertook a
‘capability review’ of the Department of Health. This was a follow-up of a review in 2006. Gus O’Donnell the Cabinet Secretary and Head of the Home Civil Service observed that while the Department of Health has made substantial progress it needed to further demonstrate an ability to work together across departmental and sector boundaries (Cabinet Office 2009).

In our own research, we found that new arrangements were being planned to separate out rather more the NHS chief executive group from the Department so that the latter was not perceived quite so much as ‘interfering in management’. The muddying of the waters was also seen to be disadvantageous for the Department too because, when Nigel Crisp was at the helm, many of the senior policy people in the Department were perceived as NHS managers rather than bona fide career civil servants with the breadth of experience from other departments of state.

We talked to senior officials in the Prime Minster’s Policy Development Unit. This Unit was established in 2001 by the PM under Michael Barber. Its purpose was to join up government and focus sharp attention on key priorities in health, education and crime. The delivery chain for health was described as ‘linear’. The PDU described its key priorities as: delivering targets such as the 4 hour wait in A&E and the 18 week maximum wait for treatment, MRSA reduction targets and improved treatment of long term conditions.

Senior policy staff at the DH maintained that while the size of Richmond House staff could and should reduce they must retain responsibility for system design and system integrity, price setting, funding, setting any priorities through future operating frameworks, defining information requirements, ensuring ultimate public accountability to parliament, health improvement, health protection and horizon scanning. This then was the remit for national level governance.

Our interviews with members of the DH policy team confirmed the notion that the aim was to align and fit a range of initiatives and reforms into a ‘coherent reform strategy’. There was also an acknowledgement that there was an active attempt at national level to find and create this coherence and that this had not as yet been fully achieved. The 2005 Health Reform in England Programme outlines the policy framework and there was a further clarification document in July 2006. Notably, we found that the Policy Development Unit of the Prime Ministers Office had its own ‘map’ of reforms and the Cabinet Office also had views and influence. The pattern of multiple influences on the shaping of policy was a very significant feature of governance at national level. Not only did it mean that there was an extra risk of variation in emphases in policy, it also fuelled the suspicion among senior clinicians and managers at trust level that central policy and directives were often driven by ‘political considerations’. Even within the Department of Health itself we found multiple agendas and multiple sources of influence. One very senior policy advisor observed: “Different parts of the department interface with different constituencies who naturally lobby for their own specific interests. So, each of us tends to come at this with different perspectives and different emphases. We need commonly agreed
policy and coherent policy agenda but I would not pretend that we have fully achieved that yet” (DH interview 1, 2007)

The policy map being used in the DH by this particular advisor is shown below (Figure 2)

**Figure 2. Overall ‘Map’ of NHS Governance**

- **Self-sustaining Reforms**
  - More choice for patients
  - Practice Based Commissioners
  - Stronger PCTs with fair funding

- **Transactions**
  - Money following patients (Payment by results)
  - All Trusts able to apply for FT status
  - New providers, e.g. social enterprise
  - Independent Sector adding capacity and innovation

- **Choice and Voice**
  - Better Care
  - Better patient experience
  - Better value for money
  - Better information
  - Regulation for access and quality

- **Provider Diversity**
  - Source: DH (2007)

The figure reveals the perceived ‘balance’ between the multiple principles of high-level governance – i.e. an admixture of markets, hierarchy and collaboration/networks.

We found that policy makers readily understood and accepted that the way in which the reforms are interpreted at different levels will be crucial. There was a notable concern to re-engage the physicians and the Darzi review was seen as a way to help this. There was also some expectation of possible resistance from the trusts – ‘as providers they will naturally resist disturbance’. But equally, the ‘compass’ was said to be the need to ‘restate the quality agenda which is paramount to everything we are trying to do’. Intriguingly it was also said that ‘It is difficult to describe the current policy mix, in some ways it was easier in 1990s to describe the internal market but now we have a more complex set of governance principles’ (DH interview 2, 2007).

There was a recognition in the DH that multiple initiatives – were being pursued simultaneously and these often had diverse and different pedigrees. For example, new delivery systems for health care were being developed, at the same time others were pushing strongly for elements of choice and challenge. Yet others wished to stress the value of cooperation within the federated NHS as a site of common endeavour. Additionally, there was a stated need to balance building relations with ‘the Service’ yet
also wanting to ‘drive reforms’ in that service. There was a wish to ‘disentangle the noise of resistance to reform from genuine design flaws and from problems simply caused by communication problems’ (DH interview 3, 2007).

The succession of different Secretaries of State each with their own styles and concerns led to disruptions to the smooth flow of a governance reform roll-out. Some came in to office and drove with clear determination, others were said to have been relatively passive and to have presided over a ‘policy hiatus’. The overall result was multiple KPIs and different sets of principles ‘perhaps disguised by merging them in one policy document’. As a consequence, the reform design which emerged was at times ‘piecemeal, incremental and messy’. At the times of our interviews (2007 and 2008) the department was seeking coherence and a new Policy and Strategy Directorate was charged with developing this.

One of our sources argued that the main reform focus was on the acute part of the service – especially that part concerned with elective treatments. But there was recognition that some related aspects such as A&E and consultant to consultant referrals were difficult to manage. The idea of using commissioning – and therefore the PCTs as the key instrument was raised by other respondents at the centre.

Three models were described to us – each of which was said to forms part of the overall reform strategy:

1. Centrally-driven (vertical direction/regulation) being reduced but certainly retained
2. Commissioning model (a form of business to business contracting)
3. Competition and market model - choice as the incentive provider.

Our respondents suggested that the DH was seeking to use all three types of governance simultaneously. Though there was a declared aim to bring about a shift of emphasis to the second and the third modes. With regard to the commissioning model there was an expectation that ‘each PCT should look to the particular need of their local populations and therefore for needs and service to differ quite significantly – for example, childcare might be a priority in Manchester and older folk a priority in Devon’ (DH interview 2, 2008). Thus, the different policy makers at national level were describing and urging some ‘blend’ of commissioning (contracting) and choice. The latter was perceived to be wanted by the public and was supported they said in the ‘programme of public consultations’. It was at the same time expected that ‘naturally the providers do not welcome this’.

As one senior policy official said:

At the heart of the Reform Programme is devolution. And we are trying to create a self-sustaining system. This means getting the flow of information right and the incentives right. You can look at this through the commissioner side and on the provider side. For the provider side the challenge for those organisation is, how they align the imperatives on them, with the payment of the individual clinical teams ... it’s a
combination of empowerment and accountability, by making sure that you’ve got the clinical information, patient’s experience information, financial information. (DH Policy Advisor 3, 2008)

This was a fairly optimistic assessment of progress. In addition there were some reflections from the centre about the way more radical innovations might unfold:

We are aware of consultants who have been entrepreneurial and launched their own consultant chambers so they can set up as a business. They may even quit their hospital posts. Admittedly, there aren’t that many who have gone that far. I mean, I know of companies that have been running for a while. We’ve had a group of anaesthetists, there’s a few in some specialities such as orthopaedics. It’s a logical extension of the profit centre. It’s not exactly something that the Department especially favours or encourages but we find it interesting. It brings with it all sorts of issues. Suppose you’ve got four lots of orthopaedic surgeons in a local area, who are competing under our Choice policy, and you’ve managed to get the waiting list down and they’ve lost a lot of private income. They may then form a ‘carpentry-is-us’ across the local area and then, sell it back to the different providers. You’ve actually fundamentally created a new monopoly! And if lots of clinicians were in chambers it would be a nightmare to run a hospital (DH interview 3, 2008).

Then there was also commentary about the implications of the Foundation Trust experiment:

From our perspective the purpose of FTs is essentially to end the dependency culture, in the sense of, looking back to the Mothership. The challenge has been those organisations that can’t get there. There are those trusts in special financial measures. A lot of the non-FT’s go to the SHA and say “We might be able to make half the deficit we projected”. And the kind of game plan that goes around that. And actually, that’s one of the tricks, we’ve still got quite a lot of that and then the deals that are done between the trust executive and the SHA execs. All sorts of gaming occurs, those trusts in surplus have become used to hiding this so that the SHA will not claw it back and the others in deficit exaggerate the extent, so all sorts of deals are done. It’s just not mature. The FT system should be better; the trusts should at least be able to stand on their own two feet. So, devolution in that sense is critically important (DH interview 3, 2008).

The other key element of devolution discussed in this round of interviews at the centre was commissioning. Both PBC and what eventually became known as World Class Commissioning were very much to the fore in the department’s thinking: ‘The key trick in all this, to get the reform to bite, is how you try to get the incentives right in order to engage the people actually delivering it making it happen.’

In summary, from a critical standpoint it could be argued that it is difficult to discern an overall and aligned plan among these various levers, drivers
and accountabilities which were introduced by different agents in order to stimulate innovation and change. One informant used the metaphor of a ‘series of waves (e.g. WCC, PBR and PBC) introduced into the system, all becoming confused and horribly entangled as they hit the shore’. From a more benign perspective, it was suggested by some policy makers that the array of initiatives, albeit introduced by different ministers at different times could be made to align and that the system was benefiting from healthy experimentation.

3.1.2 National level regulators

In this section we report our findings on interviews with Monitor, the HCC, the Appointments Commission, The NHS Confederation, the National Patients and Safety Agency, and the National Clinical Directors (the Tsars).

Monitor extended its role in April 2009 by announcing new reporting requirements for all NHS Foundation Trusts. Thus Monitor has gone beyond its initial focus on finance and corporate governance and now requires that quality of care and the way trusts plan to improve quality are included as part of their Annual Reports. The requirement followed a consultation between Monitor, NHS East of England, the Care Quality Commission (CQC) and the Department of Health. Quality reports are intended to develop more transparent and accountable public reporting and to ensure that boards have clear priorities and plans for driving improvement. They are also designed to lead towards the development of ‘Quality Accounts’, which from 2010 are to be a legal requirement for all NHS organisations as set out in High Quality Care for All.

Monitor plans to expand its size as well as its functions: it has plans in place to double its expenditure over the next 3 years. In its recent Plan (Monitor May 2009) Monitor’s Executive Chair noted that the organisational culture will be adapted to empower its staff to make decisions more autonomously whilst maintaining challenge. Monitor also says that it has revised its assessment process in response to the Mid-Staffordshire Foundation Trust scandal. It now looks at “a broader range of information on clinical quality”.

The national clinical directors were a relatively new idea. Until 1997, apart from public health people and a number of chief medical officers there had not been senior clinicians in the Department of Health. As one said, there ‘had been no proper clinicians’. The national service frameworks provided the impetus because for each speciality such as cancer or coronary heart disease, they wanted a senior clinician involved. There are now 8 ‘National Tsars’, two or three of these appointments now have wider portfolios such as the national clinical lead for primary care. These national directors sometimes have specific targets – for example, the lead for emergency care started with a very narrow focus which was to implement the 98% achievement for the maximum four hour wait accident and emergency departments, and that has now widened into all urgent care not just A&E.

The governance of these national clinical directors and their own role in governance of the service remains ill-defined. As one of these directors
said: ‘There is a degree of freedom as a national clinical director. No one quite knows what you’re supposed to be doing, which gives you a remit to do quite a lot’.

Another observed:

So, you’ve got [a few] of us who are senior clinicians in the Department. We can get to ministers in a way that an ordinary civil servant can’t, and so we have power in that sense, and influence, but we have no real power in a formal sense. We can say what we like, and I do, but people can ignore it. But, because we are senior clinical figures [...] whether you like it or not, people listen and that’s slightly scary at times.

(National Clinical Director)

The amount of influence they exercise in the Department seemed to fluctuate. At the moment, clinical leadership is a key theme and so the national clinical directors current play a major influence, they front-up a lot of things (for example, one of them has been asked to examine the top-up payments issue). Before that, there was a period ‘when the glass ceiling came down, and any senior meetings of the Department, we were out. We didn’t fit into what was then a command and control approach which the top of the office had for a year or two, and because we said what we thought, etc., we couldn’t be pushed around. And it didn’t fit neatly into the model structure; that model. But then the top of the office got kicked out, and we came back in. So we have variable influence in the Department’. At the time of the research in 2008 it was described as quite strong. A key role which they perceived for themselves was to interface with the profession. They are the main conduit to the colleges and the BMA. ‘I sit on the BMA, on the committee for example, and we are seen as the respectable face of the Department. In that sense it’s very important that we don’t behave like civil servants because, obviously, we lose credibility. People will come to me and say, “For God’s sake, why don’t you tell the minister X”? And I’ll say, fine. And I do if it makes sense. And so we have that two-way flow with the professions and with the NHS. So I think that’s important’.

We see here an attempt to establish a certain kind of independent voice and a determination not to be merely spokespersons for the Ministers.

According to one of these National Clinical Directors ‘The profession has been very dishonest over the years about the quality of care we’ve delivered around the clock, and what I’m saying is we’ve got to be up front about that, and the public have to be told that if they want high quality care, then there will be fewer hospitals doing it. Then they have to travel a bit further, but when they get there, it’s going to be better’.

The national clinical directors sometimes work together and seek to persuade players in various health economies to undertake detailed reviews of their plans for reconfiguration. ‘Yesterday I spent a morning on the south coast as an urgent request from the Secretary of State… the remit was: Do their plans make clinical sense? Our role ultimately is based on persuasion’.
‘Our job is to stop people looking on policies as a way of preventing action, but to start looking at them as prompts. Too many people in the trusts seem to seek to find ways to circumvent the policies. I try to show them that better care is the objective and starting from quality and safety is a good point of departure. I made it clear to the PCT and the acute trust yesterday that they needed a combined front of the hospital. I’m not having this stupidity of… you know, there’s a PCT bed and secondary care bed, and people get shuffled from one to the other. Run it as a combined operation, and renegotiate the tariff and PBR’.

These national professional roles, although lacking direct authority, nonetheless carried influence: ‘If I go in somewhere and say to the chief exec “You need two more consultants” they would tend to follow that advice. They know they are being very closely observed’.

“I feel I have the freedom, to say publicly as well as privately, that I think certain policies are inappropriate or a load of dross. I have two or three times had little messages from upstairs that, did you really say that at some meeting? And my answer to that will usually be a plain “Yes”.

It could be argued that in spite of these rather maverick posts, the attempt to create an underlying quality framework for the NHS has the appearance of an assemblage of initiatives. The connectivity of a systematic, easily-explainable, approach seems to be missing. On the other, hand the potential for a behaviourally-based quality improvement model which seems to be what the Tsars advocate, could also be questioned on the grounds that the result might be that the service continues to be reactive to messages and depending on the strength of the messenger.

Summary

The national level architects of governance systems – and the regulators – were highly conscious that they were creating new governance arrangements and that to some degree the emergent structures and processes were experimental. They also tended to recognise that multiple principles and logics were in play and that a great deal of intelligent work would have to be done by trust level directors in order to make the most of the new approaches and the new freedoms. We turn next to interpretations and sense-making at the level of the Strategic Health Authorities.

3.1.3 Governance of Strategic Health Authorities

The ten Strategic Health Authorities (SHAs) are the bridges between the central governance regime represented by the Department and the NHS trusts and PCTs in the health authority territories. In accord with our central research question about governance design, and interpretation of, and reaction to design we were primarily interested at SHA level with how they were choosing to interpret their role in governance terms. To what extent, for example, would they simply act as the conduit for central governance and to what extent might they seek to seize the idea of devolution in order to develop an intermediate tier of meaningful governance?
The fact that SHAs have a governance structure complete with their own boards with executive and non-executive directors suggests that governance of some form is meant to happen at this level; it does not suggest that these should be mere regional offices disseminating a central message. As more acute trust (NHS trusts) graduate to Foundation Trust status the role of the SHAs increasingly shifts to a focus on the PCTs.

The SHA chief executives tended to agree on the general role of the SHAs: to balance the books while meeting the targets, capability development of the trusts – acute and PCTs, as well as capability development for leadership – both clinical and managerial. These were the common themes. There was also some desire by a number of the informants (chief executives, chairs and non executive directors of SHAs) to refer to the role of their SHA in maintaining some kind of regional identity and sometimes expressing this as a form of ‘advocacy’ for the region. The strategic plans produced in response to the Darzi review tended to give credence to this. But, as we will show, this dimension was outweighed by their role as conduits of central governance.

We asked about distinctive differences between SHAs. Chairs in particular made some attempt to suggest their were regional differences but chief executives tended to accept that in practice they did not detect that the NHS England Chief Executive had much interest in them adding too much of a local flavour. This centralising tendency and the associated uniformity is indicated in the following commentary from one of the SHA chief executives:

> If I went to David [Nicholson] and said to him – I’ve got my own assurance... and local delivery plan and say, well, I’m a sort of hands-off SHA chief executive, that would be the last sentence I ever said. He expects us to have it absolutely pinned down; he expects to know what the assurance framework is, he expects to have seen it. (SHA Chief Executive 1)

This approach was reflected also in David Nicholson’s belief that it was right to remind all the leaders of the Foundation Trusts that they were still all part of one NHS. This view, expressed in a letter to all FT chief executives, triggered a critical reaction from the Executive Chair of Monitor. This uncertainty and tension about the nature of the new governance mosaic is illustrated by this point. It is illustrated by critical incidents such as the method of appointment of chief executives of Mental Health Foundation Trusts and acute FTs where, in a break with former practice, the SHA chief executives may no longer be invited to be on the panel and may not even be consulted at all. When these incidents are reported to David Nicholson he is said to be ‘uncomfortable’ with this trend.

We asked at the centre for a view about their practical expectations of the SHAs. One answer was that as the chief executives of the SHAs are now part of the NHS Management Board they can help establish and shape national policy. To this extent, rather than translating a given policy they could be seen as owning an agreed policy. At the very least, it was said,
they ‘should have better understanding of it rather than having it done to
them’.

With regard to how they relate to their local organisations was said to be
‘up to them’

_I don’t think we advise them in any shape or form how to handle their
PCTs, except to say there must be clear lines of accountability back to
the SHA. And one thing we’re saying is there should be an urgent care
board, and a health economy with all the partners, pharmacy, social
services, ambulances… everyone involved, and that should be
advising the PCT on how to spend its money on urgent care, and the
effectiveness of that. And the way they’re doing it would be performance
managed by the SHA. But we stop at that point. (Central policy maker)._

On the other hand, as noted, SHAs have their own governing boards and so
there is an implication that this could be an important governance tier. How
would these bodies seek to behave, how would the role be seen from the
SHA level by the key actors – chief executives, chairs and non-executive
directors?

The first point to note is that the SHA chief executives recognised the idea
of governance operating at two levels – the wider architecture of the NHS
relationships and the narrower idea of boards. The interplay between these
modes of governance was also recognised and accepted.

The second key point is that the SHA chief executives in the main were very
clear that despite the existence of boards etc at SHA level their priority was
to understand and deliver central government policy on healthcare. One of
the Chief Executives made this point very clearly:

_I’ve got to be able to look over my little kingdom and be able to say that
the things that the Government want to be happening in health care are
happening on my patch. If the Prime Minister tipped up tomorrow, I
could take him to a range of things that show how we are modernising
the NHS. (SHA Chief Executive 2)_

This intent to deliver what is asked extends it seems even to those grey
areas where consensus is stretched and doubts about ideology creep in. For
example, delivery of the waiting list targets was generally welcomed and
was delivered but the intent to install private sector capacity of 15% in the
elective areas was less supported but given attention none the less
(irrespective of whether that capacity was needed). Hence, part of the
scenario of ‘could I take the Prime Minister to see reform in action?’
included could I show evidence of the independent sector? Likewise in the
contention zone was the PFIs – these were described as “the only game in
town” if new big modern capital projects were wanted despite reservations
at SHA level about the limited risk shouldered by the private sector.

The lines of accountability were also described as clear and unambiguous:

_The overriding messages are very clear. As an SHA Chief Exec, I’m a
member of the Department’s Management Board. I have a weekly… one
hour with David Nicholson the NHS Chief Executive, because he’s my line_
managers. So he’s my boss. I work for him and I’m his management team. So there will be no equivocating... it will be going round the patch, what are the problems, what are the issues, you know... and then he’ll be giving me some team messages from the Department about what’s on the Department’s agenda. Then once a month, I spend two days in London and the first afternoon is the SHA Execs getting together to... you know, pat each other on the back and swap sob stories. Then, the following morning, we meet with the Secretary of State and the Ministerial team as a group of Chief Execs... it’s a big group, but it’s not overwhelming. There’s ten of us, ten Chairs, a Ministerial team of about five and the top management would be... so there’s probably about 30 people. The Secretary of State for health will walk in and say these are the top items on my list. That’s what we deliver. (SHA Chief Executive 1)

In governance terms the link with No.10 and the Prime Minister – a point we remarked on in the national level section above – is reconfirmed here.

We [the ten chief executives] then go into the NHS Management Team meeting with, David Nicholson and his senior management team in the Department of Health. So we then meet as a management group, about 20 of us, and we just whack through the business of the day. The analogy I use you know, if we are an insurance based system now, the NHS is your insurer, the Government of the day tells you what you’re entitled to through your citizenship as it happens, but your policy... you know, you’re going to wait 18 weeks for this, you’ll see a GP in this amount of time, we’ll start of your choice in these ways, and it’s our job to get out there and make sure that what the Government of the day wants the health service to deliver, we deliver. (SHA Chief Executive 1)

Thus, from a Chief Executive point of view, the role of the SHA is clear: ‘what the Government of the day wants the health service to deliver, we deliver’.

Up to this level at least the role of Government in the governance of the health service is apparent. And the central and political nature of that driving policy is made even more apparent when the influence of No 10 and the Prime Minister is noted:

We’ll occasionally meet the Prime Minister... and more frequently we meet with his adviser, and he’s very clear that the Prime Minister spends... a day a week, sometimes even two days a week, on the health service. It’s very high on his agenda, and it does actually feel that the real messages are coming from him, the Prime Minister. (SHA Chief Executive 2)

The ‘real messages’ are thus perceived to be those stemming from No. 10 and the crucial purpose and mission of the SHA is seen by the chief executives as the ‘delivery’ of these messages and their successful implementation. The process for doing this was also clearly explained by the chief executives. For example, this is how one of them described the process of ensuring appropriate action by the NHS trusts and PCTs:

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So, once a month I come back from my two days in London and then the day after I meet all my Chief Executives...pull them all together - 50 maybe 60 people, ambulance, community. and I do two things in that meeting. One, I put the message... you know, whatever the message is, I give them the message so that there’s a very straight line between me and them... they don’t come to engage in a dialogue with anybody, because they come in from all over the place and then there’s 60 of them... They’re coming to hear the word of the Department. They come to listen to what the Department’s got to say.

The NHS creates a family, and... we’re waiting to hear what the boss has got to say about where the jam’s going to be landing! And also there will be problems that are going on in their trusts that they want to hear, that the centre’s heard about, and he’s going to do something about. often the message is translated into performance targets. They still collect reams of data from us, but the targets are getting sharper, so this year, we’ve only got six key targets. So if the Government wants X to happen, it will express itself in a target. For example, Choose and Book, the cancer targets, the 18 weeks wait, health inequalities target, MRSA and so on. (SHA Chief Executive 3)

The other thing the SHA chief executives were doing in their meetings was to run wider performance monitoring. For example, one said “Right, this is where we’re at, so the money is a separate target, achieving financial balance is a separate target. So we’re all the time looking at their performance on the money and their performance on targets, and what I’ve done here... well not me, but my clever analysts, we’ve developed our own performance algorithm and we’ve come up with a risk rating for every trust, so every trust and PCT knows what its risk rating is in terms of achieving the targets. And our intervention across the system depends on what your risk rating is every month. And so your risk rating includes your financial position and things that help us track your financial position like workforce numbers and achieving cost approval programmes”. So, there is monthly monitoring of all the trusts within the SHA on a whole range of measures.

The relationship with the FTs naturally has to change when compared with the above. This is how one of the SHA Chief Executives expressed the point:

When [Named] Hospital became a foundation, [named person] didn’t any longer have to fill in his 52 weeks on this and 48 hours on that. Instead, these issues became subject to a legal contract. So, that completely changed the nature of the relationship so instead of him having me breathing down his neck on performance, he has the PCT with a legal contract saying, “I’ve contracted this level of service and you haven’t given it me”. So, the governance did change fundamentally at that point. (SHA Chief Executive 3)

In addition to these very direct lines of governance - through direction and monitoring – it was recognised by the SHA chiefs that the wider governance shifts were part of the armoury for change as well. This was seen most especially with the governance rationale of the quasi-market with multiple providers and patient choice. As one SHA Chief Executive noted “The
customer experience has got to change and the way we are trying to get the customer experience to change, apart from doing all the things like exhortation and paying people more money and demonstrating good practice, is patient choice”.

In other words:

_We are saying well, actually, if the patient doesn’t like what you’re doing, Mr Clinician, he can go up the road to somebody else who will make sure there’s lavatory paper in the toilets and they’re clean, and that the wards are clean, and that their family can visit whenever they want and not just for an hour in the afternoon. And so what we’re trying to do is drive in improvements through patient choice. So, as you see, we are moving to a variety of governance forms - putting levers into the system that will change the incentives._ (SHA Chief Executive 1)

In accord with this, it was perceived that the shift from block contracts to PBR was perhaps the biggest change which allowed other levers to be deployed. "In broader governance terms, that is the biggest factor" (SHA Chief Executive).

The future was seen as one where NHS central will have to depend primarily on the PCT commissioners to influence the system while the people actually delivering the care - the doctor and nurses and so on - would be less directly influenced by the traditional governance regime.

The rapidity with which trusts tended to rectify debt positions when this issue was highlighted as a priority is indicative of the power of centralised forms of governance working through the SHAs. Numerous examples were given to us of PCTs and other trusts which were as much as £16m overspent which within a year or so have having the problem highlighted as a ‘priority’ were able to turn this around.

_’At the moment our relationship with the Department is very diffuse and people who have worked at SHAs in times before myself said they were Halcyon days in which the performance was very clear, you knew whether you were considered a high performing SHA, in which case you were more or less left alone to get on and do your own thing, or you were considered a risk, in which case you were heavily performance managed. But now, there’s requests coming from all over the Department. It’s not clear where policy ends and operational management begins._

The perceived limits to the power of SHAs vis a via FTs is revealed in the following observation by an SHA Chief Executive:

_Slightly more worrying, is {named} Hospital, Dr Foster – I don’t know if you saw it a couple of weeks ago put into their league tables bottom ten for hospital mortality. Now, I’m pulling-in all my chief executives who are in the bottom ten because I had others who were also in the bottom ten, and we’ve written to [named FT Chief Exec] to say “Are you prepared to come in and talk to us about what you’re doing about hospital rates of mortality and improving the figure?”. And he said, “no”._
He didn’t want to talk to us about it. And what we’ve got to do now is go to the PCT and say you’re commissioning this service, you’re paying for the service and you’re going to have to get in there and challenge them. Why should you be paying for a service that’s poor quality? (SHA Chief Executive 3)

The hierarchical mode of governance is seen there to have been relinquished. In its place is the attempted use of the PCTs as commissioners. David Nicholson ‘will be left presiding over part of the system which most members of the public quite frankly don’t see as the real NHS’. ‘Just to make life even more interesting, commissioning is historically what we’re worst at. And so we’ve managed to give away the thing that we’re good at and hold on to the thing that we’re bad at’.

Other SHA chiefs took a different view and argued that FTs, if only due to their scale, continue to have a legitimate seat at the table clinically and managerially and must be included in any strategic and coordinated attempt to shape and craft the future of ‘the healthcare industry’. Alongside that right and that independence, it is argued, goes the responsibility to recognise regional interdependence and the need for some common standards. Many of the SHA executives were aware that they were engaged in a subtle balance - seeking collaboration, seeking to make competition work, and seeking to make what remains of hierarchy and control work.

“From where I sit I see that the Department has a strong and genuine belief that Foundation Trusts should run their own business. I don’t think David is minded to go back on the deal. I think he believes in that, just as when he was a trust chief exec he would have strongly defended his own organisation. But at the same time, much of the machinery of the department says, actually, we’d like to keep control particularly when the going gets tough, we really face that with something really difficult, so there is this continual tension, actually, in the Department, and it comes to play in areas of hospital infection, financial control, whatever it is that’s the issue of the moment, the department itself I think struggles with that. Now, clearly it’s part of the job of the SHA, and my colleagues will say this differently from their own standpoint, to handle whatever pressure comes out of the NHS management board in such a way that it lands locally. (SHA Chief Executive 1)

In one SHA the tendency is to make quite clear what the must-do’s are and to spell these out. In another, the SHA chief executive would run their monthly meetings/forums with their trust heads and describe the direction the department wishes to go in, but leave spaces for the trust level chief executives present to find their own solutions to these destinations.

Central direction is not of course a new development. Some of the regions were traditionally very directive. A few argued that, in comparison, the current situation with all its contradictions and tensions is “Far more complicated, far more nuanced, in the past all the trusts were accountable to us in a linear fashion, and it just feels 180 degrees different. We are now seeking to create strategic leadership”. Not all senior SHA executives however agreed with this assessment.
In the light of the above, why do the SHAs need boards? We put this question to SHA chief executives, chairs and NEDs. One SHA chief executive assessed the situation as follows:

_Frankly, I am not sure that we do need boards. You need a non-executive chairman appointed by the Appointments Commission. They can have a line of professional leadership through to the Foundation Trust Chair. And so the role of the chair seems to be very clear. But the role of the board, I think is more open for debate. On the trust side, the board meets in public, creating a sense of accountability and people can attend the public board meetings, and to the trappings of the board, I think brings it all to the accountability. The structure of the board in terms of governance brings some useful functions into focus. But, fundamentally, I would not think that if you took the board away, but kept the chairman, it would necessarily be any less effective. So, I don’t know that the board is an intrinsic component of our success._ (SHA Chief Executive 3)

But, the commissioning process was viewed rather different: ‘I think the power of commissioning comes from its local leadership role [in the hands of PCTs]. So for me, the objective is to cut the commissioners as much slack to manage their market as possible, and not to second-guess them. We're interested in their process as well, but fundamentally they are not there to be used as a conduit for power, they're there to run their own systems. As a default I can always do that if I have to, but I have to honestly say that in all the months I've been here, that is not the normal modus operandi’. (SHA Chief Executive 2)

As noted above, the different SHAs engaged in varying degree of leadership of the trusts in their territories. Some were very active in providing frameworks and processes and diagnostic tools for the trusts. One SHA Chair had constructed an elaborate diagnostic questionnaire for use by trust chairs and NEDs.

This instrument was designed ‘to take the best out of the Combined Code on Corporate Governance and modify it to suit the needs of a Public Body and NHS [Named SHA] in particular. The main principle is that boards should undertake a formal rigorous annual evaluation of their own performance and that of their committees and individual directors’. Some SHAs also had detailed risk-assessment reports and could view these at a moments notice. These combined reports on performance and also on process assessments.

The skills involved in chairing an SHA board – and by extension other NHS boards are captured by the following from a Chairman of one of the main SHAs in the country:

_When I’m chairing a board, I would certainly be very clear in my plan of approach on every issue. I would be very careful, for instance, in terms of who I would invite to speak first on a subject, for instance. One of the things about chairing is that very, very few people will ever know what it is that you’re really doing. And the very best work that chairmen do is_
invisible. And most of the work I do in managing my board is actually
done privately, but I’d work out, and I have a pretty good idea where the
emotional feelings would be on certain things. And I would, maybe, for
example, build up a volume of opinion, knowing fine well what would
happen, in order to stress a particular person out around the table, and
then watch the reactions. I do an awful lot through that sort of
observation (SHA Chairman 2).

This Chairman also had certain standards in mind and was able and willing
to communicate these and insist upon them:

It would be well-known to members of my board that if papers came in
that were under, let’s say, a certain standard, they would immediately be
put in the trash-can, and the item would be crossed off the agenda. I
don’t have to tell them that. One of the things that comes out quite a lot
when you look at the way in which boards are performing and behaving,
there are complaints about the quality of the papers that they receive.
Are they too long? Are they too detailed? Are the main points either
hidden or not there? Are they late? And so on and so forth. So actually,
leading and showing people, very quickly, what sort of quality of material
you would expect, is actually pretty critical if you’re chairing a board.
And if it doesn’t actually fit, so, in other words, bad material means you
couldn’t have a quality board meeting. So therefore, if the material is
substandard, and again, I’m an incrementalist, so I wouldn’t expect
people to be perfect on day one... (SHA Chair 2).

When the SHA chairs were asked to whom they were accountable there was
much uncertainty: a number said ‘Probably to the Secretary of State’ or
some version of that phrase. When asked about the word ‘probably’ this
was one Chairman’s reply: “Yeah, well, we don’t know because it’s never
been properly defined. But then I’m the kind of person who doesn’t need it
to be well-defined because I recognise the difficulty associated with that
definition”.

Views varied as to whether PCT chairs had a line of accountability to the
SHA Chair. Some thought they did, others said ‘if a PCT chairman said to
me that I was her boss I would say “no I am not”’. Another Chair argued: ‘I
would argue privately that the NHS does not have a chief executive. It’s got
a Chief Operating Officer called David Nicholson. I don’t believe David’s a
Chief Executive. What the NHS has is an Executive Chairman, called the
Secretary of State. It’s got a Management Board which is, essentially,
executive and it falls foul of various governance rules’. The argument is that
‘if you are not careful the boards of the SHAs could become quite
peripheral’.

This chairman of an SHA also argued that ‘the case against the need for an
SHA board is stronger than the case for’. The reason stated was that, in
reality, the NHS is very centralised and the real scope for variation at SHA
level in policy level terms is limited. The case for boards is the flip side of
this reasoning – i.e. to counteract at least in part that overweening
centralisation.
Another governance function of the SHAs is that they tend to keep tight control over capital expenditure.

What’s interesting about trusts is their sovereignty, and therefore, the limits on SHA influence, because I don’t have that many well-defined powers of authority over them. I do have some. For example, I have a very strong control over capital expenditure, for instance. What I would do, which I have done in the Strategic Health Authority itself, is to delegate very little in terms of the limits on the capital spend. So I make sure, given that we have strong control over relatively few things, that we can influence strategy by agreeing or not with capital spend. But the Department of Health does not consult with me when it buggers about and increases the delegated authorities to primary care trusts.

There are two aspects of governance here – one facing upwards to the DH where the issue is one of control. The other is downwards to the trusts – and the PCTs in particular where the degree of influence is the issue. Capital expenditure is clearly one key lever. But there are others. In London the Framework for Action for London was conceived at SHA level but then the 31 primary care trusts were persuaded to accept and own it. It became ‘theirs’ and they had to lead the consultation process to have it accepted.

The case for SHA board governance was made by a London SHA NED: ‘The contribution of the governance system of the board at SHA level is fundamentally all about can we show we add value? If it hadn’t have been for us and the board, you would have nothing like the approach to risk management that you see in London SHA. Bear in mind, most of what we now do in our risk management in the SHA, was foreign territory to most people. You’ve now got an executive team that are actually not just buying into it, they’re finding it extremely useful. If there hadn’t been a non-executive community operating on the board in London SHA there would not have been a good definition of strategy’.

### 3.1.4 Summary

The main findings from our interviews at the national level with the designers of the governance arrangements can be summarised as follows. First, there was a shared view that reform of NHS governance – the way it should be run – was absolutely necessary. Second, that there were a variety of principles constituting the alternative approach – but central to these was the idea of devolved governance in some form or other. Third, the varieties of principles (more patient choice, provider diversity, challenge and competition, stronger commissioners) were recognised as in tension with each other so that market, hierarchy and networks were all part of the mix. There was however an attempt to make it all as coherent as possible. Fourth, there was an argument that there were some differences in style between some of the SHAs and that these differences largely stemmed from the personalities of their chief executives. Finally, it was accepted that there was uncertainty about how all this would be received and acted upon by key players in the trusts (clinicians and managers alike). The idea that this was something of an experiment’ was not refuted by those we interviewed at
the centre. The main thrust of our research project was designed to explore how these actors at trust level would interpret and respond to this governance reform package and its inherent set of varied incentives.
Findings about Governance at Trust Level

In this section we seek to provide answers to the second, third and fourth questions of our main questions:

**How do organisational level managers (chief executives and their teams) interpret and respond to the policy message they receive concerning governance and organisation?**

**What organisation and governance design principles are used by organisation level directors and managers?**

**What perceptions do healthcare staffs have about the new governance arrangements and how are they responding?**

To answer these questions we designed and executed a series of interviews and a programme of case studies in six primary care trusts, six acute trusts and two mental health trusts. We start with the PCTs as these remain more closely within the influence of the SHAs as reviewed above. Findings from the Foundation Trusts – both acute and mental health are reviewed next as they, in theory at least, should reveal more radical shifts in governance.

During the period of investigation, there was a general emphasis upon devolution of governance and accountability to ‘trusts’. For the PCTs this meant fewer and supposedly more powerful institutions. Moreover, the role of PCTs was further clarified as their provider-side responsibilities were pushed to the periphery and their commissioning role became prioritised. The launch of the World Class Commissioning initiative introduced a template of functions and competences and an associated regime of inspection and developmental support. PCTs (or NHS ‘local’) thus became key agents of change in driving the new governance architecture as described in policy terms above.

The provider trusts (acute and mental health) in England were expected to transform their governance arrangements in one significant regard at least – they were expected to be, or to become, NHS Foundation Trusts. NHS Foundation Trusts are not-for-profit, public benefit corporations. As of Spring 2009 the majority of provider trusts had successfully achieved FT status and were thus independent board-governed organisations. There were 120 Foundation Trusts of which 36 were mental health trusts. Approximately 20 hospitals or MH trusts are expected to miss the deadline of December 2010. Those unable to meet the government’s deadline face either radical restructuring or face becoming part of a target list for existing Foundation Trusts looking for takeover opportunities.

The implications for governance arising from these initiatives are in theory quite profound. In formal terms at least, the FTs are no longer subject to direction by government or the DH, they are supposed to enjoy greater freedom to decide their own strategy and the way services are run. Democratic legitimacy shifts from Westminster to systems of local accountability – notably to members, governors and boards. At the same
time they are also accountable to their commissioners (mainly PCTs) through contracts. They are regulated by Monitor. NHS Foundation Trusts are intended to be more responsive to the needs and wishes of their local communities – anyone who lives in the area, works for a Foundation Trust, or has been a patient or service user there, can become a member of the trust. The members elect the board of governors. The board of governors in turn appoint the chairman of the trust - or at least they do when the incumbent chair comes up for re-election.

The extent to which, and the ways in which, directors of trusts responded to these opportunities and demands are issues we explore below. We begin with a review of findings from the PCTs and we then move on to present findings from the acute trusts and mental health trusts.
4 Findings about Governance of NHS Primary Care Trusts (PCTs)

This section reveals our findings in the first instance through a close examination of the key aspects of PCT governance reporting the results from six comparative case studies of PCTs supplemented with data from snapshot interviews with directors from a further twenty other PCTs. From this detailed work, a number of working hypotheses are derived. Second, the results of our national postal survey are presented and discussed.

The central debate running through much of the material is the extent to which, on the one hand, PCTs have secured local governance of health and well-being issues and, on the other hand, the view that governance is so circumscribed and so counter-acted by other forces that, in reality, the centre continues to exert crucial influence. As we will show, different actors leaned towards different interpretations and conclusions in relation to this core controversy. A summary of the 6 PCT case studies is shown in Table 3.
<table>
<thead>
<tr>
<th>THE SIX PCT CASES</th>
<th>LOCATION PROFILE</th>
<th>2007/8</th>
<th>KEY GOVERNANCE FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. South Thames PCT</td>
<td>Inner London</td>
<td>Medium size: Between £400m to £600m annual spend. 300,000 to 400,000 population 900-1200 NHS staff 200-250 GPs in more than 50 practices</td>
<td>Struggling to make find its governance role Too small UoR Fair/Good QoS Fair/Fair</td>
</tr>
<tr>
<td>2. North Thames PCT</td>
<td>Inner London</td>
<td>Medium size: Between £400m to £600m annual spend 200,000 to 250,000 population 900-1200 NHS staff 150 to 200 GPs</td>
<td>Board turbulence UoR Fair/Good QoS Fair/Fair Too small</td>
</tr>
<tr>
<td>3. Midlands PCT</td>
<td>Midlands</td>
<td>Large size: £950m - £1200m &gt; 650,000 population &gt; 5,000 NHS staff &gt; 400 NHS Plan GPs</td>
<td>Much improved in its governance</td>
</tr>
<tr>
<td>4. North West PCT</td>
<td>North West large city</td>
<td>Medium size 200,000 to 250,000 population 150 to 200 GPs in &gt; 35 practices</td>
<td>Excellent in UoR and QoS</td>
</tr>
<tr>
<td>5. South West PCT</td>
<td>South West moderate size city</td>
<td>£600m - £700m 400,000 – 500,000 population &gt; 2,500 NHS staff &gt; 350 NHS Plan GPs</td>
<td>UoR Good/Good QoS Fair/Fair</td>
</tr>
<tr>
<td>6. South of England PCT</td>
<td>County PCT</td>
<td>Large £950m - £1200m 750,000 population &gt; 5,000 NHS staff &gt; 500 NHS Plan GPs</td>
<td>UoR: Weak/good QoS: Fair/Fair</td>
</tr>
</tbody>
</table>
4.1 The key issues

The key policy developments which affected the governance of PCTs were described in the first section of this report. Now we turn to an examination of how local actors made sense of these polices.

The main issues were:

- **The governance status of PCTs** (the extent to which they had achieved devolved autonomy from the SHAs; the extent to which they had established local leadership; the lines of accountability to and from PCTs to other bodies)

- **Boards as agents of governance** (the significance or otherwise of boards; board membership roles - chairs, chief executives, NEDs etc; the strategic role of boards; the role of boards in monitoring and managing performance and quality)

- **Clinical engagement in governance** and healthcare staff perceptions of governance

- **Partnership governance** (joint governance with local authorities, the public and patients)

4.1.1 The governance status of PCTs

A familiar cause for complaint from PCT directors was the perceived Cinderella status of PCTs compared with the large acute trusts. As one Chair said 'It's a mockery of governance, we spend over £1bn but we cannot set the pay for our senior managers'. Numerous directors pointed out the discrepancy and the extent to which senior managerial salaries in the FTs exceeded those which PCTs could offer. In consequence, PCTs felt vulnerable to the loss of talent as 'the career building is still done in the acute sector'. Complaints such as this were used to question the extent to which governance had genuinely been devolved to PCT boards.

The NHS has been searching for many years for a suitable model for governance and for boards. It was argued by a number of board members that the fundamental problem is that these boards are 'essentially third tier bodies operating with a pretence of being something higher, the whole thing needs a fundamental re-think' (PCT Chief Executive).

To help uncover what board members thought they were essentially there to do we asked them about the priorities for PCT boards. The responses were revealing. Many pointed to the phase when huge, indeed paramount, emphasis seemed to be upon attaining financial balance. A majority of board members reported that they saw finance as the biggest priority of all certainly for a time. Many pointed to the fate of chief executives and others who had not got to grips with this particular priority.

Some NEDs were critical of the lack of clear and unambiguous priorities. As one expressed the point 'I can never be sure of the priorities of the board, I will need to read them out to you'.
Of course it is important to recognise that attitudes and perceptions are not fixed. Perspectives evolve. There were numerous claims of a growing acceptance of change towards the new governance arrangements. For example, one Chair with vast experience noted how, when he gave an address just 10 years ago and talked about ‘customers’ he was ‘hissed and booed’ by the clinicians, ‘now this kind of approach is seen as just common sense’.

**Defending strategic objectives against incursions from the SHA**

Our respondents shared a perception of the role of their PCT board in setting strategic objectives, and saw this as depending on managing a complex relationship with the SHA. On the one hand, it was important for strategic objectives to encompass the national priorities set out in Vital Signs. This was seen as giving the PCT the right to then identify additional local targets. In this sense, the SHA could be seen as a reliable support for the PCT earning the autonomy to determine its strategic objectives:

> ...we take seriously our license to operate and we take seriously our autonomy ..we recognise that if we want to prioritise things that aren’t on the national agenda, then we need to deliver first on that national agenda stuff.

On the other hand, the SHAs were often seen as the source of capricious directives that might cut across the PCT’s previously agreed objectives:

> I think the real challenges come from a sense that we get a direction to set sail in and then mid-year or two-thirds of the way into the year, you suddenly get different messages from the SHA which you still adhere to because it’s coming from the Department of Health. As much as you’re encouraged to make long-term plans, I get a sense of, well, we make all the long-term plans we want, but if...so there isn’t a sense of freedom as the ideology that was intended, but I don’t blame the SHA for that. You accept it because we are part of one firm and if that firm wants widgets then so be it (PCT Chief Executive).

This kind of benign view of the SHA was often linked to a view of the SHA as putting in place appropriate collaborative commissioning arrangements between PCTs, and also tackling reconfigurations of acute providers in the region which could not come within the scope of a single PCT.

However, other respondents expressed overt frustration and even anger at what they considered to be unnecessary direct interventions by the SHA, for example in supplying what was felt to be overly prescriptive guidance and a stage by stage programme for producing five year strategic plans.

**Lines of accountability**

A crucial question of governance is to ask to whom key figures are accountable. We put this question to each of the chief executives. It proved to be revealing. As one said:

> ‘This is an interesting question and one that I have often debated with my chief exec colleagues around the country and they have very
different views. Personally, I see myself very much as accountable to the board of the PCT. It is through that board that I get suspended if something goes wrong. But precedents have definitely been set elsewhere where the line of accountability quite clearly runs through the Strategic Health Authority’ (PCT Chief Executive).

But another Chief Executive was distinctly uncomfortable with the idea in the job description that he was accountable to the Chairman and the board he wanted to ensure his line of accountability was to the Strategic Health Authority. Partly, it seemed, this was because this is what he was accustomed to, and partly because he felt more comfortable with the idea of upward accountability as part of his perceived longer-term career plan. Upward accountability also more closely matched his idea of the prevailing underlying ‘model’ of the NHS.

Other PCT chief executives were, on the other hand, more welcoming of being accountable to their boards. In part this was seen as a release from the perceived inadequacies of the previous regime. Under the old PCT to SHA relationship the pattern was relatively clear: the Chair of the PCT board did the appraisal of the Chief Executive but there was also an important one to one meeting with the chief exec of the SHA which again discussed performance and according to some chief executives was also ‘effectively an appraisal’. A few SHAs have extended this one-to-one ‘review’ with all board directors of the PCT.

Some PCT chief executives were comfortable with that arrangement. As one said, ‘In the past, a struggling chief exec would have the chief exec of the SHA put their arm around them and have a chat about alternative possibilities’. In other words, the reporting line to the SHA was perceived to offer an escape route should that prove necessary. Whereas, some PCT chief executives felt exposed and vulnerable if they saw their alternative master as the Chair of their PCT, as one said, ‘If your relationship with the Chair goes wrong, you are effectively looking for another job’.

This tension between looking primarily upwards to the SHA or horizontally to the Chair and board was a running theme in many of the case studies. One clue to the apparent appropriate response was to consider the appointment process for PCT chief executives. Normally, this is done by a panel led by the Chair of the PCT while the external panel member is usually the SHA chief executive (in this way the dual reporting and accountability is in a sense set up from the start and continues with reporting). One PCT chief executive claimed that ‘the message we get from our SHA is to control the NEDs, they cannot be allowed to impede our targets’. Many others while recognising the value of having voices at the board which reflect local interests, remained cautious about having ‘elected members with their own agendas’. To avoid this, some executives placed primary emphasis on recruiting NEDs on the basis of skills.

Recent signals from the Department have suggested scope for greater PCT freedoms but a number of chief executives were sceptical. For example, one observed: ‘This is a rhetoric I have heard before – there was for instance Nigel Crisp’s famous 80/20 shift, but actions absolutely did not support it’
Further, WCC allows for 3 to 5 year strategy plans. But our SHA has issued a telephone book sized document of ‘guidance’ and sent an inordinately long questionnaire. This does not suggest to me a letting go. Likewise, there were complaints about excessive and heavy-handed monitoring. The Planning Guidance from the SHAs were perceived as ‘half guidance, half prescription’. In sum, there was divided opinion about the extent to which the PCTs were truly free to govern.

The multiple lines of accountability sometimes led to frustration. One PCT Chief Executive when discussing lessons from other systems admitted:

> To be frank, we look with some envy at the vigour and innovativeness of some of the integrated healthcare organisations in the USA, but they have a big advantage they have much stronger governance and can get things done more easily than we can.

Interviewer: That’s very interesting. What do you mean when you say ‘strong governance’?

Chief Executive: Well [...hesitates] they have more... more .. authority, we have all this confusion of multiple stakeholders and all this quasi-democracy. It takes us years to make changes...

The pull between competing priorities was a familiar concern found in the six case studies and in the wider programme of interviews. Large numbers of NEDs and executive board members talked about the desire to use resources effectively and to address the health inequalities agenda while seeking to move resources outside the hospital. Yet, at the same time, they sought to do all these things while maintaining the viability of ‘our local DGH’. These, and the wider issue of the overall objectives of the PCT, were commonly expressed concerns by those charged with governing the PCTs. Some directors sought to close ranks and to challenge the acute trusts in their areas while other directors sought more collaborative relationships. Similar balancing of tensions was found in relation to the requirement to ‘develop a market’. While this was a tenet of the WCC agenda some directors were more persuaded by what they perceived their local populations wanted and in some cases they believed that a more market-like pattern was not desired. This kind of policy tension reflected competing pulls in governance.

The same point could be seen reflected in the debate about the new sharp focus on commissioning and the associated ‘neglect’ of provision. The latter was now perceived as very much a ‘poor relation’ and there were some deep reservations about this. Directors in a PCT with a total of 2,800 staff of which 2,200 were employed on provider side said that it seemed ‘odd to have this skewed focus’. Another example would be Practice Based Commissioning. Numerous directors detected a clear and inherent conflict of interest in this policy.

The diversity of views about governance is indicated by the following quotes:
“Some executive directors and clinicians see governance processes as a pain in the neck. They don’t realise that if we can assure our board then that is also safeguarding them” (Director of Corporate Governance and Quality Development in a PCT)

“Governance, quite simply, is the key to it all” (PCT Chairman)

‘The problem with governance is that it tends to dull the imagination, people play safe, they play for the draw rather than the win’ (NED).

‘Many directors of governance are, like me, clinical directors and nurses we are assumed to know about governance but we don’t. It’s a steep learning curve. (Director of Governance)

‘In truth, NEDs and even PCT chairs have less power and influence than a local councillor’ (PCT Chair and former councillor).

The doubts tended to be about the influence of governance when compared to the continued influence of the centre, the power of the chief executive in so far as local influence is a reality, and various expressions of reservations about where the remit of governance begins and ends. A common complaint was that ‘PCTs are over-managed – from higher up’. There were also many questions asked about who decides what type of clinical solution to offer when there are choices between short term versus long term quality of outcome and cost equations to consider.

4.1.2 Boards as agents of governance

Some of the critiques of the boards as agents of governance were not of the principles but rather of the difficulties encountered in making the principles work in practice. For example, as one Chief Executive argued ‘Despite the reforms of 2006 we still need more NEDs with legal and business experience of a high level. We are having to turn to management consultants to help us with board effectiveness’.

But there were also many expressions of a more positive nature and some of these reflected fundamental convictions that the principles of governance are crucial for PCTs. For example:

‘Governance for me is about transparency of decisions, transparency of processes and yes of rules and regulations’ (Director of Corporate Services).

A number of chairs and NEDs contended that they were truer representatives of their towns and of the public; much more so than the executives. It was frequently pointed out by NEDs that while they tended to live in the borough the full-time executive directors usually commuted-in from more pleasant rural or suburban environs. As one Chair argued: ‘We are of the city as opposed to merely temporary serving the city – unlike the executives’.

NEDs as a group were often the champions of the idea of a localised governance approach for PCTs. Yet as a sub-group they could also be the most critical. For example, they made assessments such as ‘the official
purpose of the board is to give strategic direction, but in practice it is unsatisfactory in its operation’. NEDs hold very different expectations – we encountered many who were disappointed about the amount of influence they were allowed. ‘I was close to resigning’ was a statement made by a number of NEDs from various PCTs. Some NEDs were frustrated that they could not more easily hold to account or replace the executives in the board. As one NED noted: “It took us 18 months to replace an ineffective chief executive”.

The kinds of problems the NEDs complained about can be summarised as follows:

- ‘Starved of information’
- ‘Excessively long board agendas’ – too much irrelevant detail – takes 12 hours to read the board papers – too often merely just ‘to note’ they don’t really require a decision. Swamped with paper because officials seem to think they have to get their paper to the board – as if that is the culmination of 2 months work on a project.
- Poor quality information
- Minutes distributed late – can take 6 weeks
- Fobbed-off
- No colour printing for NEDs unlike Execs
- Informed of too much after the event
- Don’t always get the notes & action points from important meetings attended by senior managers
- Late PEC minutes
- Not clear whether instructions from SHA is mandatory – but executives ‘jump to it and imply to us that it in effect it is’
- Surface behaviour and hidden frustrations
- In effect the board as a board only meets 6 times a year.
- We are too often just in ratification mode (too many things have to be done at speed)
- The executives too fixated with trying to avoid media disasters
- Public engagement – only the usual suspects turn up
- Reporting and accountability terribly complicated
- Low visibility of PBC from a board perspective
- NEDs overstretched and under-remunerated (one narrative)
- ’Underutilised’ (an alternative narrative)
- Executive team diaries full of meetings, no time to think
- ‘As a NED I don’t feel I have contributed as much as I could have done’
Board membership and overall conception of governance

For illustrative purposes we show below the board composition of two of the case study PCTs – one in inner London and one in an inner city in the North West of England (Table 4). In these and other cases, not all the directors who made up the senior management team had executive director posts on the board. However, in both PCTs, all directors regularly attended board meetings and presented routine reports as well as policy papers for discussion. For officers at director level, having board membership appeared to determine only formal voting rights rather than actual participation in board meetings. That said, there are interesting differences between the roles that carry board membership between the two PCTs. North-West has board roles for directors of both commissioning and provider services, whereas Inner London does not. And whilst the North-West board has a Director of Clinical and Professional Leadership, with a nursing management background, the part time Medical Director, a GP, is not included. In Inner London, the part-time Medical Director, again a GP, does sit on the board and in addition, the Chair of the PEC is included as a non-executive director. North-West PCT had no such role.

Both boards are characterised by continuity of service in executive director roles. In Inner London all but one Executive Director has been in place since 2002 or very shortly afterwards, and the same was true of all of the North-West executive directors. In Inner London, all of the non executive directors (NEDs) other than the two PEC members came to the end of their terms in late 2007 or early 2008 and were replaced by new appointments, made through the NHS Appointments Commission and involving formal advertising and application processes. Four new NEDs joined the board during the first half of 2008. North-West has used the same formal processes when NEDs have reached the end of their first term, but this has resulted in greater continuity with four of the seven NEDs being involved with the PCT since 2002. The North-West Chair has also been in post throughout the life of the PCT, whereas the Inner London Chair arrived in September 2007.

Both Chief Executives saw themselves as, first and foremost, accountable to the board and its chair – the person who was responsible for their annual appraisal. Both saw themselves as having a close working relationship with their Chair. As one put it:

I have a personal coach who is a long, well experienced senior person formally in the NHS. It was one of the first key messages he gave me, was really that my relationship with my Chairman is the most important relationship. If that relationship goes wrong, I’m in trouble. (PCT CEO)
### Table 4. Comparison of membership of PCT Boards

<table>
<thead>
<tr>
<th>Inner London PCT Board</th>
<th>North-West PCT Board</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chair</strong></td>
<td><strong>Chair</strong></td>
</tr>
<tr>
<td><strong>Executive Directors</strong></td>
<td><strong>Non Executive Directors</strong></td>
</tr>
<tr>
<td>1. Chief Executive</td>
<td>1. PEC Chair (GP)</td>
</tr>
<tr>
<td>2. Director of Nursing &amp; Joint Director of Quality &amp; Professional Development</td>
<td>2. PEC Member (Mental Health clinician)</td>
</tr>
<tr>
<td>3. Medical Director &amp; Joint Director of Quality &amp; Professional Development</td>
<td>3. NED (local carers network)</td>
</tr>
<tr>
<td>4. Director of Finance &amp; Information</td>
<td>4. NED (older people network)</td>
</tr>
<tr>
<td>5. Director of Public Health</td>
<td>5. NED (Accountant)</td>
</tr>
<tr>
<td>6. NED (Voluntary sector senior management)</td>
<td>6. Executive Director of Provider Services</td>
</tr>
<tr>
<td>7. NED (local solicitor)</td>
<td></td>
</tr>
</tbody>
</table>

**Director level officers not on the Board**

- **Inner London PCT Board**
  - Director of Service Strategy & Commissioning (jobshare)
  - Director of Primary Care & Community Services
  - Director of HR & Corporate Affairs

- **North-West PCT Board**
  - Medical Director
  - Director of Human Resources

However, both CEs were also aware of having a strong line of accountability also to the CE of the SHA, described by one as follows:

*Well, what I do is I share with [the CE of the SHA] in advance my objectives, and then any recent output I’ve got in terms of my appraisal discussions with [the PCT Chair]. That is the way it used to operate with the old Strategic Health Authority as well.*

Both CEs thought that in reality there was dual channel performance management and accountability between themselves and their PCT Chair on one side, and the SHA on the other. Both spoke in terms of defending the
performance and autonomy of the PCT against possible challenges and incursions from the SHA, regarding their Chair as an ally rather than as a task master. In this sense there was in both cases a strong sentient boundary around the entire board, as an entity needing to account for itself to the SHA. Both CEs were aware that, even though they were formally appointed by and accountable to their Chair, in fact the SHA wielded considerable power over them, even to the point of requiring their removal if it considered their performance unsatisfactory. In the forthright words of one of the CEs:

I feel much more comforted that I am accountable to my board rather than through some extension of a central line of control to the Department of Health. The reason I say that is because quite frankly, I have seen quite a lot of bullying and blame culture in recent years direct from the Department of Health, and for me, if our organisation is set a series of targets to deliver by the Department within its performance management framework, it’s the job of my organisation that I lead to deliver those and provided that we deliver those satisfactorily, my board will keep me in my position. I don't like to have the thought that the Secretary of State on some whim can cut across those arrangements and influence my future employment or career. That does concern me. Pragmatically I recognise that it happens, the case load is pretty solid on it. (PCT chief executive)

Turning now to how members of PCT boards in general understood their overall task, they were clear that they were there to set strategy and review its implementation. Board members also said that they were charged with making sure that relevant performance data were made available and acted on by the board and PCT officers. One CE recounted the definition of ‘governance’ that a board workshop had produced the previous day:

Setting direction, ensuring delivery against that established direction having assurance around delivery, making sure that there were plans in place, costed and directed in the right way and talked through with the right people, so it had a good chance of succeeding. And getting assurance would be, effectively, forms of monitoring, and checking against them so that we’re clear that delivery has happened. (PCT chief executive)

We now examine how PCT boards went about, respectively, strategy setting and assuring performance.

**Setting Strategy**

Members of PCT boards referred repeatedly to two related activities as central to the strategic role of the board: the preparation of a medium term (five year) commissioning strategy, indicating how services will need to be shaped to address public health priorities and improve population wellbeing; and the formulation of an annual operational plan. In the latter, service commissioning plans are brought together with detailed finances and workforce plans, indicating how the PCT is going to address national priorities set out in the annual NHS Operating Framework.
plan explains which local priorities have been identified in addition to national ones, shows how these fit with the Joint Strategic Needs Assessment of health and social care issues the PCT has undertaken with the local authority, and explains how the PCT is setting about commissioning and developing these services through providers.

There was widespread appreciation amongst those interviewed of the level of rigour and integration of thinking required to produce these plans and they were seen as vital strategic tools for the work of the PCT and the board, and not as mere empty formalisms required to justify activities. The Director of Public Health in one PCT explained how he saw the planning process as a proper enactment of the logic of using Health Needs Assessment (HNA) including the need to arrive at priorities tailored to the needs of the local population:

[HNA] gives us stats on the need, and the differential need at different points in the city, and among different age groups. And from that you derive the problem, the extent of the issue, and we can then consider what we respond to. So there’s some high level prioritisation that goes on at the board level, in terms of objectives, we’ve seen what all the issues are and what do we think we need to respond to, in theory, “what we know” [about local health needs], will feed into the local community strategy, and that would inform the local area agreement. (PCT Director of Public Health)

There was usually a pragmatic view within boards that local priorities could be defined as long as current DH national priorities were also being addressed. As one of the Chairs put it:

We don’t need to be asking for permission as long as we do the “must do’s”...

Further features of strategy formulation emerged as significant in the minds of our respondents: the way that recent NHS policy has shifted conceptions of priorities in service provision, the need to balance mandated national priorities with local ones, and the desirability of achieving stakeholder participation in priority setting.

Directors of commissioning were aware that, following the Next Stage Review, SHAs were broadening the way that they expected PCTs to think about performance, moving beyond a focus on process targets in treating illness, such as the waiting times for GP surgery appointments or for acute referrals. The new sets of priorities concern delivering more preventative and wellbeing-oriented services, and also, through engaging with World Class Commissioning, demonstrating the capability to execute the whole cycle of local health needs identification, service design, provider selection, contracting for services and service evaluation:

You know, there are things that quite rightly should be a national disgrace, like our access to early cancer screening, and early treatment, and they pop up, but they’re actually generally quite a small cohort, and you can always address those and then set them aside. The really big agenda is almost like the journey the PCTs are going to start on, which is
to shift resources from treatment into prevention, and lifestyle improvement. It's much more cost effective to do so.

... ironically, you might be getting quite decent outcomes, but if you can’t demonstrate a longer-term capacity and capability to do the job then there’s a sort of performance management role there as well (Director of Commissioning)

This strategy development process was often seen as needing to become more consultative, and consequentially more iterative, in character. Key stakeholders – from the community and from the ranks of clinicians – need to input in order to ensure the legitimacy of the resulting priorities.

Formal structures for assuring performance and risk

PCT board directors tended to recognise that arrangements for assuring performance and managing risks were in a process of transition during the period of data collection, under the combined pulls of the challenge to arrive at a more integrated governance structure and the need to separate out the provider element from the “commissioning only” PCT.

In June 2008, the Inner London PCT board had the following committees reporting to it, all chaired by NEDs:

1. Audit committee
2. Employment and remuneration committee
3. Professional executive committee (PEC)
4. Governance Committee
5. Commissioning development committee
6. Provider development committee
7. Community engagement and user Involvement committee

According to interviews with board members during 2008, the Audit committee was engaged in developing an overall Assurance Framework, identifying key risks for the PCT as a whole and how they were being managed, as well as overseeing financial audit. The PEC had an established role of communicating views from the clinical community and acting as a forum for consultation on PCT initiatives. The Governance Committee was seen by the Chair and CE as a temporary arrangement, overseeing seven subcommittees - five concerned with various aspects of quality assurance or risk management and one subcommittee concerned with emergency planning.

The last three committees were established by the Chair in late 2007 as temporary board committees intended to oversee respectively the development of systems for a more strategic and public-health oriented approach to commissioning, a distinct provider arm relating to the commissioning function, and community engagement to support the commissioning function.
Our interviews also provided direct evidence of challenging discussion of performance and assurance issues at sessions of the main board:

The board asks about how do we know what’s happening in our big acute providers, not just in our own provider units, but in Guys and St Thomas’s, and King’s. Where is the assurance that the services we are providing meet the standards? The targets are fairly cut and dried because you either meet them or you don’t, but understanding what lies behind that and whether the patient experience or the clinical assessment of the care is right or not, all those sorts of things. (PCT chief executive)

In June 2008, the Inner London PCT Chair and CE commissioned an external review of governance arrangements, carried out by an independent consultancy involving several people who had been influential in developing DH models of integrated governance. This review urged the board to speed up the process of “mainstreaming” high level performance reporting to the board as a whole, with analysis and preparation of these reports to be firmly located within the officer function rather than within the hybrid Performance committee. It also urged a rapid conclusion to the work of the Governance, Commissioning development, Provider development and Community engagement and user involvement committees, with only the Provider committee being succeeded by a permanent new governance body for the provider services.

In March 2009, the Chair and chief executive brought before the board a revised governance structure of board committees, as follows:

1. Audit committee
2. Employment and remuneration committee
3. Professional executive committee
4. Quality and governance committee, with five subcommittee (information governance, infection control, medicines management, clinical effectiveness and health and safety)
5. Autonomous Provider Organization (APO) board
6. Performance committee

Key points to note here are a decision to maintain a Quality and governance committee to oversee various aspects of quality assurance needed for the commissioning function of the PCT, with two of the its subcommittees – information governance and infection control – also expected to fulfil this function for the APO. The APO board was scheduled to take effective responsibility for the governance of provider services from April 2009, although still with ultimate accountability to the main PCT board. It was intended to establish its own Clinical Reference Group, distinct from the PEC, as well as its own subcommittees responsible for assurance systems in clinical effectiveness, safeguarding, and environmental and site management, including health and safety. In the words of the board paper:
The APO board will be a formal sub committee of the PCT board until the separation of provider services is complete. The APO will continue to work with the PCT board in relation to the transfer of Provider Services to an appropriate organisation or putting in place other arrangements relating to the future of Provider Services. The final decision on the future of Provider Services will be made by the PCT board.

Finally, the board decided to retain a (renamed) Quality and Governance Committee, and also to formalise the Performance Committee at board level. The CE saw both of these as temporary, however:

*Its job should be task, and finish. Its job should be to make sure there’s a really good system for the board, and then it disappears. Whereas we’ve been in the mindset of saying these are standing arrangements, and they will do the business away from the board table, on behalf of the board.*

If these developments in Inner London’s governance arrangements illustrate a PCT very much in transition as it grapples with integrated governance and the separation of provider services, North West’s formal structures suggest a PCT that has been in a position to ingest both principles more thoroughly. In September 2008 North-West PCT implemented a structure of groups with NED as well as executive director membership reporting to the main board as follows:

1. Audit committee
2. Remuneration committee
3. Provider services board
4. Commissioning board

There are thus two sub-boards accountable to the main board for the governance of respectively the provider services and commissioning functions of the PCT. These both relate to the corporate audit and remuneration committees, as well as to a number of officer-led subcommittees concerned with systems for quality assurance or risk management. These subcommittees consider commissioning and provider activities under separate agenda items and include: health and safety, emergency planning, education and training, workforce planning, information security, and equality and diversity.

**Performance monitoring and management**

Our interviewees in most PCTs placed considerable emphasis on the board’s role in monitoring overall PCT performance and ensuring that performance management systems were in place. Where boards were able to claim success they attributed this to having established a reputation for focussing on performance systems and being seen to demonstrate performance according to Vital Signs indicators. Successes in areas such as smoking cessation rates, teenage pregnancy incidence, prevention of recurrence of acute cardiovascular disease and the successful implementation of prescription of statins, were all widely quoted.
Members of boards however also described how they were struggling with a number of aspects of performance reporting, evaluation and management. A first issue concerned the problems of finding meaningful benchmarks for assessing performance against. This occurred in two contexts. Locally derived targets were seen as not have corresponding national benchmarks or datasets for comparison, and the performance of acute providers in areas such as patient safety was seen as needing more subtle and context-specific benchmarking in order to reveal how effective providers where actually being. The following quotes illustrate each of these points:

We have an ability to have local targets in the Local Area Agreement. And the issue around that is that, because they’re local, they don’t have the whole of the mechanics of performance management wrapped around them. The beauty of smoking quitters is that we’re measuring it, the SHA is measuring it, the PCT still measures it. The government office works quite hard to steer us if we were going to do something local at least to make it something that’s measurable and hopefully comparable. (PCT chief executive)

A second performance management issue concerned the need to strengthen a multi-perspective assessment of the performance of commissioned acute services, focussing more on clinical quality and the user experience, as well as on established measures such as waiting times. PCT boards generally showed widespread recognition that their capability to achieve this has yet to be developed in any depth, and would need to be developed in order to manage providers successfully:

There is clearly an emerging qualitative and clinical agenda around the commissioning, which we need to boost on the hospital side, so how assured are we about clinical standards, and how assured are we about the patient experience?

If we have a multiplicity of providers, how do we make sure that people get a consistently good experience and that we don’t sink to the lowest common denominator? (PCT chief executive)

A closely related concern was a recognition that there was need to strengthen consideration within the governance structure of clinical governance systems within providers.

A third set of issues with the operating of performance system concerned perceptions of straightforward gaps in meaningful information on performance in several areas of primary care, particularly in community services, and also in mental health services:

How is the board assured about the district nursing service and what it does? We have almost no data about what they do, contacts per day or the proportion of mothers-with-infants visited.

In mental health care it’s extremely difficult to measure what’s happening, because the outcomes aren’t measured very well. The information is rubbish, the clinical engagement isn’t as strong as it is on the acute side.
A fourth performance management issue took the form of recognising the limited extent to which a PCT can in fact manage the performance of GPs, given the nature of their contract, and the fact that it can only be terminated on the basis of serious deficiency in provision:

The GP contract is a unique one because I think as commissioners the national contract that we’ve got doesn’t provide us with sufficiency to do that... We cannot say three years unsatisfactory performance, you have had warnings, you’ve not turned it around, we are terminating your contract. We can’t do that...The GP gets paid on list size, but there is the performance related element in terms of the quality and outcomes framework, the QOF payments, but the vast majority of the payment relates to the number of patients he can attract on to his list.

I think with the new QOF [Quality and Outcomes Framework] framework we are beginning to make some inroads into it, but there is still an awful lot more work to do there. We as a board have certainly started to get to grips with a legacy of poor performance in primary care ... that’s gone on for many, many years. We started getting rid of some of these doctors, and that’s a first.

A fifth performance system issue concerns how to find an appropriate role for non executive directors in assessing performance. Here there were some interesting divergences between PCTs. In some, the Chief Executive had found a way of deploying NEDs to advise on performance reporting systems, assigning them to working groups responsible for designing these systems:

A bunch of managers go away, develop a system for assurance around patient safety, bring it back and show it to the board and the boards says, no, that’s not what we wanted. Common sense, and also using the skills that a lot of our non-execs bring, why not have one or two of them engaged in the piece of development work that then produces a result, which they are able to say to non-exec colleagues on the board, well, we think this is really good, actually? .

In other PCTs however, there were feelings amongst executive directors that NEDs found it difficult to take a sufficiently global stance in assessing performance, tending instead to focus on particular failures or incidences that had been drawn to their attention by members of a constituency they felt particularly accountable to:

A good performing non-exec sees the bigger picture and doesn’t think there’s any wool being pulled over his or her eyes by the exec team. They see that there’s a whole lot of work been done prior to it coming to a Broad strategy meeting or to a board meeting itself. And what they’re doing is checking that actually this piece of work or this report matches up, they link it up with the strategic aims of the organisation. You can see the good ones check it in their head.

A number of themes have a common and central organising role in the thinking of board members. Board members and other senior managers appeared to embrace and identify with the principle that a PCT should be
commissioning services with the primary goal of improving public health outcomes and reducing health inequalities within their specified population. This led to a clear set of overall performance priorities, in terms of tackling long term conditions associated with poverty and lack of previous engagement with effective healthcare:

..I do get a sense within our own board of a unity of understanding of what our priorities are...mental health problems, CHD problems, lung cancer, alcohol-related diseases; we’re not going to turn that round in a year. We’re not going to turn it around in two years and be lucky if we get the really massive impact that we want in the space of five. But nonetheless they will remain our priority.

There was widespread acceptance of the central role of commissioning in shaping services, as the key mechanism for aligning services to meet public health needs. Rather than seeing advantages in retaining a closer organisational connection between service specification and service delivery, many respondents saw a crucial advantage in having commissioners independent of all providers. They apparently relished being free from formal investments in preserving any particular provider, including the community service providers who were in the process of being separated out from the commissioning PCT.

But there were deep-seated concerns and reservations:

I think what to date we have been extremely good at is delivering input targets, because that’s the way the NHS regime has been established. Unfortunately, when you look at the evidence base about how you extend the life of people and improve their quality of life, it’s not getting good access to healthcare services; it’s about tackling those root cause determinants of ill health

A specific challenge implied by the new focus on health outcomes is to improve the information base for assessing progress with population health. Issues identified here included deciding on what the most meaningful indicators might be, as well as how to collect data on them:

The world-class commissioning processes have highlighted.. the poor information systems that we have, in our ability or capability to measure, let alone decide what it is we’re measuring...

Closely related is the issue of the timescales involved in achieving impacts on population health profiles. One Director of Commissioning felt she understood very well the kinds of preventative services that would have an impact on health inequalities and public health outcome measures, but that the timescale for real impacts would be much longer than the period assumed in NHS performance management, and too long indeed for any particular five year government to claim any credit.

There were further concerns about the coherence of overall NHS policy in supporting the new focus on public health outcomes and reducing health inequalities, given that most respondents saw this as implying a shift in emphasis from acute care to improved primary care and preventative
services. The questions our respondents asked were for example whether the NHS as a whole was willing to see resources transferred from the acute sector to primary care, and whether some resources invested in improving waiting times for acute treatment could be better invested in preventative services:

_One part of the Department of Health tells you to expand primary care and shrink hospitals, and another part says, make sure your hospital stays clean, and fantastically efficient, and earns lots of money. And without bridging the two, you need somebody to step in and say, well, actually, in order to have both of those things at their optimal level you need fewer hospitals, and where will you have fewer hospitals, which ones will close?_

Overall then, the logic of World Class Commissioning appears to be thoroughly identified with by our respondents but this leads them to identify a number of important challenges and performance issues:

- the problems of finding meaningful benchmarks for assessing performance
- the need to strengthen a multi-perspective assessment of the performance of commissioned acute services, focussing more on clinical quality and the user experience
- gaps in meaningful information on performance in several areas of primary care, particularly in community services, and also in mental health services
- the limited extent to which a PCT can in fact manage the performance of GPs
- finding an appropriate role for non executive directors in assessing performance.

### 4.1.3 Clinical engagement in governance

There were important differences between the cases in the arrangements for governance of GP practices within overall PCT governance arrangements, including the role that GPs play in setting commissioning strategy and monitoring its performance. These differences can be understood as superimposed on some basic and common core mechanisms, as follows. GP practices are formerly independent contractors to the NHS, and their performance is governed through the terms of a national standard contract, according to which they are remunerated according to numbers of patients and are accountable for maintaining standards of their staff and of treatment. They are incentivised financially to meet a number of primary care targets – for proportions of the their patient list with certain categories who are screened or treated – through the Quality and Outcomes Framework, which allows the PCT to increase payments to the practice. Standards are further assured through annual appraisals for all GPs, which are required and organised by the office of the PCT medical director.
In some of the cases GPs and other primary care clinicians had the opportunity to engage in PCT debates on strategy and decision-making on commissioning through putting themselves forward to join the PEC. Or they found influence through working on forums concerned with analysing particular care pathways, identifying the services to be commissioned and identifying and managing providers. Detailed contract management were however carried out by PCT officers. Some of the commissioning forums existed at PCT level, and some at the level of an alliance with neighbouring PCTs. GP practices were often expected to join a PBC consortium. In the case of mental health, LITs were formed.

The picture which emerged was one where PBC consortia were coming forward with a variety of business cases to commission services, but in reality only accounting for a small percentage of the aggregated indicative commissioning budget allocated to the practices making up the consortium. The PCT commissioning function also appears to have encouraged a spirit of voluntarism and variety in the focus of services commissioned through PBCs. These ranged from aspects of acute provision to additional primary care services. This is reflected in the way that PBC was treated as an additional organisational unit within the commissioning function, sitting below the various forums that oversaw detailed commissioning strategy for different care pathways, and alongside the contract management function.

The governance of PBC consortia as commissioning units also appears to have been kept quite separate from the structures within the primary care directorates that communicated with GP practices and managed them as providers. These were often area based. The result was that GP practices were involved in different roles in a complex set of governance arrangements for a range of different purposes.

The picture emerging in a number of the PCTs was one of greater integration in the governance of GP practices as providers and commissioners, and more explicit integration of both with PCT operational priorities. Some had a single PBC consortium to which all GP practices belonged. This might be tightly integrated with the PCT-level commissioning structure for acute services and centrally directed as to the services practices can themselves procure. This kind of consortium approach was also closely integrated with primary care performance management and performance development arrangements.

One Medical Director described the organisation of PBC in terms of representatives of eight clusters of GP practices being involved in the strategic planning process, thereby developing understanding of commissioning priorities across the single PBC consortium.

> We have a governance system for practice-based commissioning, whereby there’s a consortium, a single one for the whole of the district, but it’s broken into eight clusters. Each of those eight clusters has a clinical lead that works on ascribing attention to those priorities,

The PBC consortium has an operating board, which reports to the commissioning board, a sub-board of the main board. The operating board
is seen in effect as a sub-board of the commissioning board, making recommendations to the commissioning board as to how the bulk of the acute budget should be spent. The commissioning board in turn has to refer proposals to spend more than £250,000 per annum to the main trust board. The commissioning board includes clinical representatives from the PBC operating board alongside NEDs and all the executive directors, as well as the medical director.

The design of these arrangements means that in effect that clinicians have been placed at the heart of commissioning decision-making, supported by the officers of the PCT commissioning directorate in gathering evidence to design clinical pathways and evaluate potential providers. The Medical Director described this as follows:

"We’ve devolved all the budget to the PBC consortium. They’ve got virtually all the budget; apart from the tertiary care budgets and things like that. In a sense, we’ve put our money where our mouth is...the default position was it’s in with the PBC budget unless there’s a good reason for it not to be."

The quid pro quo for clinicians has been twofold. First, the PEC has been discontinued. This essentially advisory body has been superseded by the PBC operating board, located clearly within the decision-making structure for commissioning. The Commissioning Director described the difference thus:

"We’ve constructed a commissioning board, as a subcommittee of the PCT board, and that subsumes all the duties of the PEC, but it’s got a completely different governance arrangement to the PEC. So first of all it has two non-exec directors on it, one of whom is the Chair, whereas our PEC Chair was the lead GP. It completely embeds and, if you like, manages the practice-based commissioning system"

Second, and perhaps more significantly, this Medical Director, who also works part-time as GP within the PCT area, had brokered a two year agreement with his GP colleagues that they will not bid to supply services being commissioned, beyond the terms of their existing contracts. This is to avoid any conflicts of interest between their provider and commissioning roles. To compensate them financially for forgoing the opportunity to provide additional services, a local variation of the national GP incentive payment scheme has been put in place, based on practices demonstrating that they have adopted a specified bundle of “best practices” relevant to PCT operational goals, including being a member of the PBC consortium.

Crucially, this performance management arrangement is coordinated through the PBC operating board, so GPs relate to the same PCT structure for their performance management and their input into commissioning decisions. This provides a basis for relating both GP practice performance management and commissioning decision-making more transparently to the pursuit of PCT-level operating goals, whilst avoiding confusion amongst GPs as to when they are acting as providers and when as commissioners.
The Medical Director at another PCT was inclined to criticize the limited horizons of many of his colleagues, but felt that the setting up of a clear structure for GP representatives to make substantial commissioning decisions for the PCT as a whole, whilst effectively barring them from tendering for additional provider services, was a solution. This arrangement can be understood as limiting the scope for clinical engagement, in that commissioning decisions could only be made within certain categories of services not decided upon elsewhere.

A further issue in pursuing clinician engagement concerns the involvement of community service staff – mainly community nurses and allied health professionals – in the shaping of services. In a number of PCT cases, directors of primary care and the directors of nursing judged that these clinicians were in danger of being unwilling recipients of new initiatives, in particular the arrangements for the new provider arm, rather than partners in the design of services.

4.1.4 Governance of partnerships

PCTs found their commissioning activity taking place within a developing structure of various kinds of joint commissioning with other bodies – including other PCTs and local authorities. This meant the board had to delegate some aspects of the governance of commissioning and service delivery to partnership governance bodies.

Collaboration with other PCTs took two forms for PCTs. First, they were involved in regionally centralised arrangements to commission and manage numerous kinds of specialised acute services, across a range of specialisms from cancer care to ear surgery to adult mental health, which the DH has specified have to be conducted at SHA level because of the relatively low demand per head of population. This specialised commissioning was overseen by a joint committee of all PCTs within the respective region, in effect reporting to each PCT board.

Second, PCTs, in consultation with, but not led by its SHA, were developing joint commissioning arrangements for some services with smaller groupings of more immediately neighbouring PCTs. At the time of interviewing, some of the PCTs were already working with an established group of local PCTs, and the Inner London PCT was on the point of formalising joint commissioning arrangements with two neighbouring PCTs. These partnerships were by early 2009 constituted as formal boards – in one case an “association” (that is where the PCTs maintained there separate governance arrangements but worked in harmony), in the other case an “alliance” (where some governance aspects were pooled). In both cases, the partnership board again had a formal reporting relationship to the PCT main board, as an “external delegation”. The key issue was where was decision making really taking place?

Joint commissioning arrangements with the local authority were again broadly similar for the PCTs but the nature of joint commissioning is different in nature from the aggregated commissioning of health services engaged in with other PCTs. Joint commissioning with local authorities
focuses on providing health, social care and sometimes educational services to particular vulnerable groups where national policy identifies the need for such joined up provision. These “client groups” are principally six in number: the mentally ill, older people, people with learning disabilities, people with physical disabilities, substance mis-users, and children and young people. Providing services to these groups was considered by both boards to be central to reducing health inequalities. As the deputy CE of one PCT put it:

Our core priorities are health improvement and reducing health inequalities. We can’t do that without the Council. The prime one to one relationship, more than with any other organisation, I think is with Council.

In the case studies, commissioning and evaluation of health and social care services for each of the client groups was often overseen by a separate partnership commissioning board, staffed by officers and professional or clinical staff from council and from the PCT. In the case of Inner London PCT, these six joint commissioning boards reported in to the PCT through the commissioning executive function, rather than directly to the main board. In the Eastern PCT case they reported to the commissioning board. As for all PCTs, the governance of these client group services is further complicated at the level of setting strategy by the borough level Local Strategic Partnerships. These bodies are required (and funded) by the Department of Communities and Local Government, and are intended to bring together public sector, voluntary sector and private sector agencies responsible for health, social welfare, housing, employment, education and training, and law and order, to consider needs for service provision and then agree combined targets under a Local Area Agreement (LAA). The basic implication for PCTs is a need to harmonise health-related targets in the LAA with those in their own operational plan, and that the LAA then holds the PCT board accountable for achieving them.

PCTs showed awareness of the implications of Joint Area Reviews of performance in service provision for client groups that the Care Quality Commission will be undertaking during 09/10. This will look at the capability of partnerships to commission and deliver integrated services, rather than the capabilities of local authority social services and PCTs as separate commissioning bodies. The Director of Finance and Information at one PCT understood this development as follows:

We’ve got JAR this year (09/10), which is a joint area review on children’s services. We have good working together on that, to address that performance assessment, the governance around it…The Council will be the main statutory body, so they’ll be the basic kind of sector, but there will be a kind of judgement across the partnership and the partnership itself, the LSP, will be judged in that context as well…it’s going to put the emphasis on LSPs and delivery and the governance of the LSPs for the purpose of delivery, as opposed to perhaps just being about engagement.
Patient and Public Involvement (LinKs)

Local Involvement Networks (LINks) replaced patient forums from April 2008. LINks are made up of user groups, local voluntary and community sector organisations and interested individuals. PCTs, together with FTs and other NHS trusts are legally obliged to allow LINks representatives to enter their premises and view their services, and to provide LINks with information on their publicly funded services. They are able to make recommendations and suggest ideas for improving services to commissioners, providers and regulators. Though these are non binding, NHS organisations are required to respond to LINks’ recommendations and be clear what actions they will take as a result (DH 2009b). At the time of our data collection LINks were only recently established and only a few respondents judged that they were of any current particular significance in governance terms.

One of the large city PCTs we researched was trying to develop a public membership scheme – rather similar to that found within FTs but without formal election to boards. The directors argued that key interlinked priorities were better communication, legitimacy and accountability. As one said ‘We have the worst male health in England and yet curiously health in general is not seen as an issue by the population’.

Few of our PCT interviewees wanted to argue that their patient forums and local involvement networks had been effective. Patient and public engagement were seen as highly important and yet it was an aspect with which PCT boards struggled. Securing wider public engagement was seen as a huge challenge.

Developing multifaceted relationships with providers

A further dimension of partnership governance was the emergent nature of relationships between PCTs and their acute services providers. The functioning of systems was seen as requiring two contrasted elements simultaneously – on the one hand, strong elements of collaboration and identification with the needs of provider organisations, and on the other, vigilant countering of opportunistic tendencies on the part of providers.

The logic of collaboration was illustrated powerfully in accounts of how at Midlands PCT, the commissioning, finance and clinical staff have worked with a local Foundation Trust to introduce new approaches to A&E triage, based on having a small group of GPs and A&E nurses undertake an initial assessment of “walk-ins”, with a view to diverting those who do not need an A&E visit, and could more reasonably attend a booked appointment at a GP surgery. Several senior staff described this initiative, and elaborated how it was intended to improve the efficiency of the A&E department as much as improve primary care, so that the trust in question would improve its A&E performance scores and improve its attractiveness as a place for GPs throughout the region to refer patients. The Finance Director also explained that A&E expenditure by the PCT on the Foundation Trust concerned was ring-fenced for the duration of a trial of the new arrangement, so that the income of the Foundation Trust was not affected.
until it was clear that there could be efficiency savings or additional income derived from the capacity freed up.

A similar emphasis on persuasion to collaborate in the interests of the wider system of care, whilst recognising the distinctive and legitimate goals of a provider organisation, can be found in this quote from a Director of Commissioning:

\begin{quote}
Because you’re working in partnership you generally respect your colleague from another organisation...And actually getting agreement when it may not always be in an individual organisation’s interest... We’re looking after the whole population, and we have to prioritise within that. A provider will become involved with a single lens from what they provide...I often think when I’m having a really bad meeting I want to shout at everybody and say the only reason I’m here is trying to do the best I can for our population...That’s not true of providers...
\end{quote}

Several respondents also articulated the need to be vigilant in managing provider contracts, to protect the PCT against provider staff either inadvertently or consciously taking advantage of inappropriate possibilities of extracting additional income. PCT directors spoke of acute provider staff coding procedures at a higher tariff rate than the proper one, or encouraging inappropriate referrals to increase volume. One Director of Finance described a method to improve the effectiveness of contract management.

\begin{quote}
We took the staff from the Information Department who collected the data, the Commissioning Team who had the detailed knowledge of the trust and a senior member of my Finance Team, and put them together in what we call the Contracting Unit. They are responsible for the negotiation of the contract and the performance management of the contract. What they did was develop a whole series of reports about particular issues within the contract that really tests the Foundation Trust in terms of the delivery of the particular aspects of the contract... Every year we add new contract terms and we closely monitor them. We have got GPs to go through a batch of activity to look at the clinical description of that activity using the case notes and advise us. Then we have the discussion with the trust, because we have got some evidence base that the coding on that is actually wrong. 99 times out of 100 our challenges are accepted by the trust and contract modifications are made, and that is where we get to... in the first instance, £1.8 million savings.
\end{quote}

Board directors in some of the case PCTs were confident that they had thought through the governance arrangements for establishing an autonomous provider arm. However, there is also recognition that the relationship between the commissioning PCT and its provider arm will be the locus of tensions and learning, and require both collaboration and vigilance on the part of the commissioning PCT, as with any other provider.

Many of our respondents also brought out an understanding of the direction of travel for these relationships, namely transferring service provision out of acute providers into community or primary care settings, particularly for
long-term conditions. This category of “sense-making” as to how services should be designed and governed was seen in past as well as future initiatives. Some of the PCTs had put in place musculo-skeletal triage clinics led by physiotherapists that had radically changed the referral system for orthopaedics and rheumatology. In one the reorganisation of sexual health services was widely referred to:

 Sexual health is a massive reconfiguration, recognising that, actually, sexual health can be provided by self-care, and it’s very much a community service, although historically it’s been a very acute based service in clinics and yet very few need that kind of facility.

Senior staff at one PCT drew attention to an initiative whereby LIFT funding had been secured and used to build three multi-purpose health and social care centres, staffed by PCT clinicians and local authority social services staff. In one of these centres, an independent Clinical Assessment and Treatment Service for musculoskeletal problems was offered. Another centre handles all the children’s outpatient services for the borough.

In terms of future plans to reorganise care pathways and redesign where services are provided staff described a “Best Value” review of all areas of commissioned services whereby GP practice-based commissioners were working with PCT officers to explore possibilities for service redesign to reduce cost and improve clinical effectiveness simultaneously. One common line of investigation was how to reduce outpatient attendances in acute hospitals, particularly following operations, through earlier referral of patients back into GP care.

A final aspect of thinking about the relationship with providers concerned the role of new entrants to the market. Staff in a number of the PCTs made some references to isolated examples of new kinds of providers – such as new Clinical Assessment and Treatment Centres. However, the predominant focus was on improving ways of working with existing providers.

Overall, market testing and stimulating the market with new providers featured much less heavily than concepts of stimulating existing relationships by a combination of collaborative understanding, persuasion to adopt a systemic view, and vigilance to ensure that transactional terms were honoured.

Valuing commissioning partnership arrangements while recognising their complexity

PCTs were heavily involved in joint commissioning partnerships of two distinct kinds – commissioning elective and tertiary care in joint arrangements with other PCTs, and commissioning of integrated health social care for particular target groups jointly with the local authority.

The first kind of partnership arrangement seemed to pose little challenge to the sense-making about governance by commissioning directors and others. They saw such aggregated commissioning of large volume or relatively rare services as simply the most effective use of commissioning resources. The
Chief Executive of one PCT described the emerging arrangements for joint commissioning with the two neighbouring PCTs in the following terms:

*If I’m a non-executive director and you’re the director of commissioning today, I’m content that you do your work within the governance arrangements that we’ve got agreed, and you report to me periodically on what’s happening. In a sense, the new (joint) arrangements make no difference to that.*

Joint commissioning arrangements for health and social care with the local authority were generally seen as absolutely central to improving health inequalities and associated social deprivations. However, the governance and management of these arrangements was perceived as more problematic, even in the case of one of the PCTs where there was considerable pride in:

*The excellent relationships we have with the local authority, having joint commissioning posts in there, our Public Health Director is a joint post. We have joint services for learning difficulties and intermediate care, we’ve integrated teams sharing offices...I think we’ve got a really good established history of partnership working.*

However, senior people described themselves as experiencing confusion and frustration in the governance aspects of these partnerships. First, the process of agreeing joint targets as part of the Local Area Agreement was perceived as more a process of adding together the concerns of the various agencies involved, rather than analysing complex health and social issues and deriving robust targets from that analysis. According to a Director of Public Health:

*we don’t have the conversation about whether we really believe the data. ...childhood obesity is one.. there’s some doubt about how reliable the measurements are...*

Second, there were perceived gaps between agreed strategic priorities and co-ordinated implementation across the various agencies concerned. A PCT Director of Commissioning observed:

*If you’ve produced a strategy in the Strategic Partnership, like, say, the alcohol strategy, a strategy’s been written, it’s been through this organisation, through the City Council, and the Police and everybody’s said, very broadly, yes, we commit to this. So, it’s a signed-off by the Strategic Partnership, ratified at the board and Council. But when we’ve actually looked at the detail, people aren’t lined up behind it. We, in the PCT, have put money in So, in relation to the governance within the Strategic Partnership, because it’s a partnership, we don’t, really, hold each other to account... what we’ve tried to do is we’ve put together a Health and Wellbeing Board that sits under the partnership. And that’s supposed to be its area where we’re going to hold to account ...*

Third, the issue of pooling health and social care budgets for particular target groups, as a basis for truly integrated commissioning of services was
perceived as problematic in various ways. In another PCT such arrangements were yet to be properly broached:

One of the questions to be asked on the borough-based commissioning agenda is how far do you want to push joint chair, aligned integrated commissioning, with the council? At the moment we don’t really have an answer on that. Conceivably we might get into arrangements that require new and different governance. If, for instance, we were going to hand over some budget, lock stock and barrel, for them to be fully lead commissioner then clearly we would need some new governance arrangements.

In general the perception was that some such arrangements existed nominally, but were still confused in how they operated. A Director of Public Health explained that whilst the Drug and Alcohol Action Team was funded by a pooled budget under the auspices of the Local Area Agreement, decisions to invest further in it had been fraught. The Health Care Commission and the PCT had evaluated the health component of the team’s provisions highly, leading to the PCT commissioning board wanting to increase funding. The Council had considered this not within the PCT’s authority, given the pooled nature of the funding. So in this case, the PCTs own governance arrangements seem to have posed the challenge to joint decision making between agencies. In other PCTs too there was confusion about the relationship between jointly agreed targets and strategies and the decision-making power of PCT board committees. One Director complained that the commissioning development committee had no formal input into targets agreed by her chair or chief executive when sitting on the Local Strategic Partnership. There were occasions when a Local Authority cut the budget of a joint commissioning unit without consulting the PCT.

**Strengthening community engagement**

The final strand of thinking found within PCT boards was to find improved mechanisms for interaction with the local population, to establish representative views on health improvement priorities and the kinds of services required to address them. The context of this was a perception of the absolute importance of community engagement, coupled with a sense of as yet limited achievement in this area, needing to be built upon.

In Southern PCT, existing community engagement initiatives included a group of patients who read all leaflets and publicity materials for “plain English”, quarterly public meetings, run jointly with the local authority to promote awareness of health and social care services, and “public health trips”, when PCT staff go to visit particular voluntary or community groups. In Eastern PCT, the Director of Commissioning was proud of having used market researchers to gather opinions on high streets for inputting to the five-year commissioning plan, recruiting people using a template to reflect the demographics of the borough.

However, there was general dissatisfaction with the sense in which the various voices in “the community” had been brought into dialogue on health
priorities. There was also a sense of a lack of clear recipes to adopt in order to move beyond what was already in place.

*Community engagement: for me this could be a whopping great big gap in the organisation*

The Medical Director at West Midlands PCT took this thinking one stage further, seeing community engagement in terms of disseminating knowledge about health maintenance, but connecting this to the need for other supporting public policy interventions, such as the provision of facilities for exercise:

... it’s that people have to take personal responsibility for their health and life. And, actually, it’s about having public policy that enables them to make those decisions. Its around the leadership agenda and about us being leaders, locally, so that we get the partners to engage and do the right things, to have the right level of health impact. Obesity’s a really good example. The NHS ...can run as many bariatric surgeries as it wants, the bottom line is that the food manufacturers are the people to get with, it’s a government issue. But, locally, the City Council needs to do better things in schools and have better leisure facilities and they need to have areas where people can walk and use them to cycle rather than use cars

Hence, in general, all of the PCTs were struggling with the same issues of governance in relation to community engagement and the governance of partnerships. Notable also were the wide range of actors (partners, patients, voluntary groups and others) who remain outside the purview of mainstream governance.

*Provider arm separation*

The move towards the separation of the directly provided services presented special governance challenges for PCTs. The new focus on commissioning was recognised as presenting potential conflicts of interest if the PCTs own services were privileged in some way. Hence, all of the PCTs in our reviews had taken steps to erect ‘Chinese Walls’ between the two functions. Typically, a separate board or management structure was established for the provider services. However, despite the distancing of the provider services function the PCT chief executive remains technically the accounting officer. Likewise, other directors made the point that they believed that they too were technically still accountable. Analysis of the use of Board Assurance Frameworks (BAFs) suggested these risks are not being fully identified to the PCT boards.

As one Director observed, ‘We have a so-called Provider Services Board but our board secretary informs us that it has no legal status. And the arms length relationship means risk. We have less or no control and yet we are still responsible. It is crazy. And if they really do eventually fully split that will end up duplicating resources’. 

As one PCT NED observed, ‘The provider services committee solution is not really a solution at all, it doesn’t offer assurance to the PCT board. So, we
have introduced a more powerful executive group with most PCT execs on it and this reports to the main board’. Another PCT NED said ‘Governance is achieved through a Community Health Services Committee which reports to the board of the PCT’. While the split approach is supposedly transitional it highlights interesting governance issues. It was recognised by PCT directors as a big challenge from a governance viewpoint. Some said it necessitated a ‘culture shift and loyalty mindset shift’.

4.1.5 Conclusions and wider implications

We now draw some conclusions of wider relevance from these analyses of the development of the governance structures and of sense-making themes and issues. They are offered as “working hypotheses” for focussing further discussion and exploration. Again we organise our analysis under the same four main headings used to report the PCT case findings: the governance status of PCTs; boards as governance agents; clinical engagement; and partnership governance.

1. The governance status of PCTs

There was some frustration among PCT board directors that despite the official policy of ‘stronger PCTs’ that for a variety of reasons their scope for influence was undermined by the strength of some of the large acute hospital trusts and by the greater career and remuneration opportunities in these trusts. Moreover, there was a good deal of complaining about the amount of interference from SHAs and the way this curtailed governance at local level.

Given the policy background of World Class Commissioning and the Next Stage review, an important question we explored was whether the senior actors in our case studies identified with the aspiration of being the local shapers and leaders of NHS services. The answer appears to be an emphatic “yes”. In different ways almost all of those interviewed saw their PCT board as the body with responsibility for setting and delivering on health service priorities for its locality. They took the performance setting function of the board very seriously, albeit recognising that objectives were ultimately shaped and approved in dialogue with the SHA. The aspect of governance concerned with setting priorities was not a game or a set of motions to pass through without believing in their significance. It was a genuine task, to be undertaken in the spirit of accountability to the population, and to undertake it properly was apparently important to the professional identities of senior figures from a range of different backgrounds, clinical and non-clinical. At one level it is perhaps not surprising that senior public sector managers should take priority setting seriously. But their clinical and public health colleagues shared in this. In the case study PCTs irritation was expressed at interventions from the SHAs that were perceived as unhelpful, in particular the imposition of short term targets originating from the DH, which were experienced as cutting across the PCT’s own strategy and its local leadership.

The principles of setting priorities on the basis of public health data, and of consultation with the community and local partners, particularly the local
authority, were not merely accepted but appeared to be experienced as exciting and indeed liberating opportunities to think differently about health services. So, a first working hypothesis to put forward from our case studies is that the DH governance template gives PCT boards the opportunity to take on a meaningful remit and a basis for orchestrating change in the local health system that board members and other senior managers can identify with. At the same time, it poses significant challenges even at the stage of priority setting. Amongst them are finding channels for public consultations, finding a way of preserving strategic direction in the face of politically-driven performance targets conveyed by SHAs, and also having effective discussions about priorities with local authorities and other agencies involved in social care and intervention.

PCTs indicated that the process of arriving at Local Area Agreements could amount to simply adding together, or horse-trading between targets proposed by each agency separately, rather than an endeavour of shared analysis and agreement about priorities and interventions to address them.

The thinking of our interviewees on PCT performance was at one level thoroughly embedded in the performance metrics associated with the Healthcare Commission’s Health Check and the DH Vital Signs framework. They accepted the reality of needing to deliver on national tier 1 “existing commitments”, such as the 18 week referral time target, and also embraced the tier 2 national priorities where they had had to negotiate local targets with the SHA, on the basis of public health data. Local targets, making up tier 3 of Vital Signs, were seen as something the PCT had the privilege to argue for once they had convinced the SHA that they were delivering on the national priorities in tiers 1 and 2. There was some sense of frustration that locally-derived targets could not be brought more to the fore, partly because, by definition, they could not be aligned with national benchmarks.

The implication is that the NHS is at one level encouraging the setting of local targets as part of local NHS leadership, but then tacitly discouraging them because performance reporting is so much geared to comparisons across the nation. Performance against local targets is then in danger of becoming invisible.

More fundamental issues about the future direction of performance measurement concerned the need to achieve a shift in emphasis from the process or waiting-time oriented tier 1 measures to others more closely corresponding with increasing population health and wellbeing and reducing health inequalities. A second working hypothesis is thus that the governance remit and apparatus of PCTs is driving awareness of the need to focus on new kinds of performance metrics, concerned with health outcomes rather than healthcare processes. The challenge is to work out what this should mean in practice.

2. Boards as governance agents

Our Executive Director interviewees appeared to be imbued in an established, senior-level, NHS culture with known ways of performance management, risk identification and management, organised through a structure of parallel committees which collect performance reports and
scrutinise how activities are conducted, issuing and revising best practice guidelines. At the same time, they showed signs of moving beyond this, towards arrangements where risks and performance issues are considered in a way that is more integrated with other aspects of leadership and management. The non-executive directors joined these boards with expectations of influence that were often in excess of the scope for governance which they encountered in practice.

Some PCTs can be seen as having moved further along this journey than others. By the end of 2008 at North-West PCT there was no board level committee concerned solely with process governance, in the sense of identifying clinical, health and safety, financial or any other kind of risk and designing systems to make sure these risks are eliminated, minimised or detected and managed. The separation of the commissioning and provider arms of the PCT had been used as an opportunity to embed quality assurance and risk management within the functioning of each of these arms. Usually, the main PCT board saw its role as reviewing risk and quality assurance systems, rather than directly managing risks or service quality. In the more mature boards meetings and forums were seen as engaging with tasks important to taking forward the direction and management of commissioning or provision, rather than in “box-ticking” to ensure that the PCT could be seen to be doing the right thing.

But, in the less mature PCTs even very senior directors complained about the requirement to attend numerous governance committees. This suggests that the approach had not been thought-through and was not seen as meaningful. A third working hypothesis therefore is that the embedding of quality assurance and risk management into the everyday business of commissioning, or the management of the provider function, brings at minimum greater clarity as to the why such activities are important, and frees the main board up to consider strategic issues, including major risks that can only be acted upon at the level of the PCT as a whole. In other words, our case studies bear out that the direction of travel for governance arrangements mapped out in the Integrated Governance Handbook.

3. Clinical engagement

Perhaps the most striking contrasts between the cases was found in the way GPs were organised as practice-based commissioners. In some PCTs GPs were well-integrated into the governance arrangements. In others, they had been marginalised or had marginalised themselves. This had implications for how and the extent to which the clinical voice was heard in relation to decision-making on commissioning. In some of the PCTs the PBC consortia commissioned services only with approval from the commissioning directorate, and within the terms of the PCT operational plan. But they were otherwise independent of the main thrust of commissioning work, and also quite separate from performance management and improvement initiatives directed towards GP practices. In other PCTs, organisational arrangements
brought GP representatives right into the core of the PCT commissioning function, and encouraged GPs to think about their own practice performance and the needs for commissioning services in an integrated way. (Managing to do so while avoiding conflicts of interests was a further tension).

Whilst the nature of our research did not involve exploring the implications for performance of these two contrasted ways of organising clinical engagement, the arrangements in the latter set appear to have the potential to bring primary care clinical knowledge and experience more centrally into the design of primary care and acute services, and so be more suited to realising the aspirations of redesigning clinical pathways set out in the Next Stage Review. In this sense, they are an additional mechanism for performance management and risk management and they appear to provide the basis for more robust service design. Hence, a fourth working hypothesis is that integration of practice-based commissioning with PCT level commissioning and GP performance management provides a basis for a clearer focus on improving clinical pathways. It is, however, worth noting that there was little indication as to how community nurse clinicians can input into PCT commissioning. This is of some concern, given the relevance of community nursing to preventative services and the care of people with chronic long-term conditions. A further concern is that the commissioning divide may leave acute clinicians out of the frame on the assumption that they may defend vested interests and yet a pathway designed without that seamless flow may not serve patients well. The roots of this divide may be traced back to governance.

4. Governance of partnerships

Our case studies both show that senior commissioning staff understood well their task of arranging the conditions for collaboration with local authorities and with other PCTs. They also were acutely aware of the need to find better ways to work with providers, to discuss how to improve services, whilst also holding them to account for fair charging once contracts have been agreed. It is significant that a number of the commissioners we spoke to had experience of working in acute provider organisations as well as in primary and community care, and could describe in detail the stances and motivations of different kinds of clinicians as well as of NHS managers. A fifth working hypothesis is then that the performance of commissioning is not only underpinned by the commissioning competencies set out for World Class Commissioning, but also by the ability of commissioners to understand the range of clinical and financial concerns that are important in different kinds of provider organisations.

The area of governance regarded as most problematic in the case studies were the arrangements for setting priorities and managing performance for services in partnership with the local authority and other social care agencies. Above all, there were dissatisfactions about the consistency of implementation in addressing priorities that had apparently been agreed at the level of the Local Strategic Partnership. And there was some genuine confusion as to what it means to pool budgets to provide integrated services for particular target groups, such as children, the elderly, or those with
learning disabilities. A sixth and final working hypothesis is then that the confusions in governance and implementation of joint health and social care services will require the development of clearer management and governance arrangements for health and social care professionals to work together.

We can now turn to a review of findings from our national survey of PCTs.

4.2 Findings from the Postal Survey of NHS Primary Care Trusts

This section begins with a brief overview of the methodology used. It then presents findings focussing initially on individual level data, exploring difference and similarities of perceptions amongst key groups on the Board. The analysis then moves to organisational level data exploring links between governance and performance.

4.2.1 Methodology

Measures of governance in acute trusts were developed from a questionnaire administered to all board members of all PCTs in England in 2008. This profile of governance was then correlated with a number of board and Trust performance measures. These performance measures were derived from the Healthcare Commission AHC measures and from data derived from the World Class Commissioning reviews. In sum, this meant that we could compare our governance profiles with the available key performance indicators for all PCTs in England. In the simplest of terms we were seeking an answer to the questions: Does governance matter? If so, how and to what extent?

We designed the survey instruments to cover three main levels:

- Micro-level aspects of the concept of governance including the reportage of practices and operations of boards and other aspects of governance within Trusts,
- Meso-level forms that explore the nature and content of relations within a particular strategic health authority,
- Macro-level issues such as the relationship with key regulators, perceptions of regulatory and policy environments.

This broad perspective enables the exploration of a wide range of potential relationships between governance and performance. With an initial focus on board level operation, the sample frame for the survey was defined as board members of every PCT in England. The organisational sample frame was generated through a list of PCTs derived from NHS service directories. The list of individual board members was generated through accessing PCT websites. In total, including both pilot and full rollout stages, 669 responses

1 Copies of the questionnaire and details of the pilot study are provided in the Technical Appendix.
were received from the sample of 2,006 individuals, representing an overall response rate of 33.3%.

Once data at the individual level was collated and cleaned a second organisational level dataset was produced. This dataset offers an insight into governance at the organisational level. A number of the variables at the organisational level are simple aggregate indicators of responses to individual questions, in the form of a mean level of the indicator for an organisation. A number, however, are conceptually driven composite level indicators designed to access broader thematic areas apposite to the current discussion. These variables are described in full in the Technical Appendix. They present key indicators used in analysing governance styles within PCTs - the organisational level dataset also includes a set of performance variables gleaned from governmental sources.

The discussion of findings is contained in two sections:

The first section considers data relating to individual respondents. This section discusses overall perceptions of governance within the sample population and seeks to discern salient differences and similarities across all respondents.

The second section moves from the individual to the organisational level and broadens the discussion to explore links between governance and performance. This analysis uses aggregated individual question responses and a series of composite indicators expressing additional and specifically organisational level aspects of governance. The first part adopts a univariate descriptive approach, exploring potential links between governance and performance on Annual Health Check measures. The second part extends this analysis by adopting a multivariate approach. Here we explore the interrelationships amongst the derived governance variables and then go on to see how these relate, taken as a whole, to various measures of performance. Initially, factor analysis (more specifically, Principal Components Analysis) provides useful insights into the set of governance variables and prepares the way for further investigation of the links between governance and performance via multiple regression analysis (OLS regression).

### 4.2.2 Aspects of Governance

This section considers governance in terms of the perceptions of different categories of those within the board. Firstly, it examines the non-executives (including the chair) and then secondly, the executive director group. With regards to this latter, the executives are split into those with a clinical role and those non-clinical².

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² Of course, it is possible for other members of the board to have a clinical background - however we have focussed on the level for the role, i.e. whether the role covers a specific medical remit and expertise. Indeed, clinical executives input on the board (though formally broad ranging) carries an additional element in terms of eliciting an expert medical opinion on matters apposite to board practice.
This discussion of PCTs covers two aspects of governance, namely:

i. perceptions of the reformed governance and regulatory environment

ii. orientation towards key external regulators

This part is descriptive and univariate in approach, exploring similarities and difference across these groups. Concerning cross-tabular information, the standard chi-square ($X^2$) test is used to test whether such differences can be considered statistically significant. The test statistic, where the test is appropriate, is reported beneath the table with a standard threshold of $p<.05$ to report statistical significance.

For the purposes of exposition, tables in this and subsequent sections that summarise responses to Likert-style questions are presented using either a five or threefold categorisation of responses. In a number of cases, a three category response table has the advantage of being easier to comprehend, makes the overall narrative somewhat clearer and makes the chi-square test more robust and elucidatory (see Table 5). In other cases it elides certain distinctions and a five point response is retained. This re-classification is simple and structured as follows:

### Table 5. Response categories

<table>
<thead>
<tr>
<th>Original five categories</th>
<th>Recoded three categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree (1)</td>
<td>Disagree (1,2)</td>
</tr>
<tr>
<td>Disagree (2)</td>
<td></td>
</tr>
<tr>
<td>Neither Agree nor Disagree (3)</td>
<td>Neither Agree nor Disagree (3)</td>
</tr>
<tr>
<td>Agree (4)</td>
<td>Agree (4,5)</td>
</tr>
<tr>
<td>Strongly Agree (5)</td>
<td></td>
</tr>
</tbody>
</table>

### i. Perceptions of the reformed governance and regulatory environment

We begin with findings on directors perceptions about government policy concerning PCT governance.

#### a. Perceptions about coherence and clarity of reforms.

In general, the macro pattern of governance was seen as coherent and logical. There was a clear pattern of divergence across the key groups within boards. While 47.4% of clinical executives are unable to fathom a clarity of purpose and coherence in recent reforms, only 18.3% of the Non-clinical executives were unable to see clarity. On the other side of the coin, a clear majority of board executives (70.3%) claimed to discern clarity and coherence (Table 6). It seems that there is fundamental misalignment of perception toward the overall coherence of recent reforms as understood by different groups of PCT board members.
Table 6. Board Members Perceptions of Clarity and Coherence in NHS Reforms

<table>
<thead>
<tr>
<th>Clear and coherent logic to reforms</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exec (Non-Clinical)</strong></td>
<td>32</td>
<td>20</td>
<td>123</td>
<td>175</td>
</tr>
<tr>
<td>18.30%</td>
<td>11.40%</td>
<td>70.30%</td>
<td></td>
<td>100.00%</td>
</tr>
<tr>
<td><strong>Exec (Clinical)</strong></td>
<td>72</td>
<td>25</td>
<td>55</td>
<td>152</td>
</tr>
<tr>
<td>47.40%</td>
<td>16.40%</td>
<td>36.20%</td>
<td></td>
<td>100.00%</td>
</tr>
<tr>
<td><strong>Non-Exec</strong></td>
<td>95</td>
<td>61</td>
<td>180</td>
<td>336</td>
</tr>
<tr>
<td>28.30%</td>
<td>18.20%</td>
<td>53.60%</td>
<td></td>
<td>100.00%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>199</td>
<td>106</td>
<td>358</td>
<td>663</td>
</tr>
<tr>
<td>30.00%</td>
<td>16.00%</td>
<td>54.00%</td>
<td></td>
<td>100.00%</td>
</tr>
</tbody>
</table>

$X^2(4, 663) = 44.43, p = .000$

**b. Reforms and behaviour**

We asked board members whether the centrally-driven reforms had changed behaviours at trust level to a significant degree. A large majority (83.3%) of the respondents agreed that they had (irrespective of whether they see these changes as positive or otherwise). 88.6% of non-clinical executives and 86.9% percent of clinical executives perceived significant changes while a somewhat lower proportion (78.9%) of non-executives agreed. These differences were statistically significant.

However, these reforms may be seen as having positive or negative impacts on behaviour. In this respect, the executive directors (non clinical) and the non-executives made a positive assessment (72.4% and 73.4% respectively). This contrasts sharply with a more critical held by the clinical executives (Table 7). This result accords with this group’s perception of the overall coherence of the reforms and represents the Clinical members of boards to be significantly out of alignment with their colleagues. It represents an interesting emerging perceptive dissonance which may manifest itself in board practice. These results were statistically significant.
Table 7. Perceptions of Positive or Negative Impacts on Behaviour

<table>
<thead>
<tr>
<th>Changes in behaviour are positive</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exec (Non-Clinical)</td>
<td>23</td>
<td>17</td>
<td>105</td>
<td>145</td>
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<td></td>
<td>15.90%</td>
<td>11.70%</td>
<td>72.40%</td>
<td>100.00%</td>
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<tr>
<td>Exec (Clinical)</td>
<td>31</td>
<td>29</td>
<td>62</td>
<td>122</td>
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<tr>
<td></td>
<td>25.40%</td>
<td>23.80%</td>
<td>50.80%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Non-Exec</td>
<td>20</td>
<td>47</td>
<td>185</td>
<td>252</td>
</tr>
<tr>
<td></td>
<td>7.90%</td>
<td>18.70%</td>
<td>73.40%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>93</td>
<td>352</td>
<td>519</td>
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<td></td>
<td>14.30%</td>
<td>17.90%</td>
<td>67.80%</td>
<td>100.00%</td>
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</table>

X^2(4, 519)=30.29, p=.000

Summary

In overall terms the assessment of recent reforms is broadly positive, the majority of respondents perceive both coherence and positive and significant changes in behaviour. However, there is a noticeable percentage who cannot attest to this positive view and even express the opposite.

ii. Orientation towards key external regulators

As discussed earlier in this report, PCTs are faced with a web of external organisations which can exert authority over their practices. This section explores how board members interpret the priorities of the PCTs to be in congruence with three key external organisations.

a. SHA

The SHAs represent a middle level tier of governance. We were interested in the first instance in how PCT directors were responding to that tier in governance terms and the first issue was the extent to which they perceived alignment or misalignment of priorities between the two levels.

Overall, the majority of respondents (59.6%) saw an alignment of priorities with the PCT, however a noticeable 40.4% did not agree that there was alignment, half of these perceived a mismatch. Non-clinical executives were most apparent in this regard (22.0%) with clinical executives reporting slightly less incidence of mismatch – although the majority perceive alignment (Table 8). The broad message is that there is a noticeable incidence of perceptions of mismatch between the priorities of PCTs and SHAs.

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3 This question does not appear in the Acute Trust questionnaire.
Table 8. Judgements about order of priorities compared to SHA priorities

<table>
<thead>
<tr>
<th>Priorities – same as SHA</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exec (Non-Clinical)</td>
<td>38</td>
<td>27</td>
<td>108</td>
<td>173</td>
</tr>
<tr>
<td></td>
<td>22.00%</td>
<td>15.60%</td>
<td>62.40%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Exec (Clinical)</td>
<td>28</td>
<td>29</td>
<td>95</td>
<td>152</td>
</tr>
<tr>
<td></td>
<td>18.40%</td>
<td>19.10%</td>
<td>62.50%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Non-Exec</td>
<td>67</td>
<td>77</td>
<td>189</td>
<td>333</td>
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<td></td>
<td>20.10%</td>
<td>23.10%</td>
<td>56.80%</td>
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</tr>
<tr>
<td>Total</td>
<td>133</td>
<td>133</td>
<td>392</td>
<td>658</td>
</tr>
<tr>
<td></td>
<td>20.20%</td>
<td>20.20%</td>
<td>59.60%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

\[X^2(4, 658)= 4.712, \ p=.318\]

b. Healthcare Commission

The Healthcare Commission’s assessments of the quality of PCTs are frequently used to construct league tables and it might be assumed that PCT board directors would want to respond to these assessments. League tables of PCTs are perhaps more abstract and of less immediate interest to patients – for example, patients can choose to shift their demand to a particular Acute Trust based on these tables, whereas individuals exist within a distinct PCT boundary.

Table 9. Judgements about order of priorities compared to HCC priorities

<table>
<thead>
<tr>
<th>Priorities – same as Healthcare Commission</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exec (Non-Clinical)</td>
<td>39</td>
<td>41</td>
<td>93</td>
<td>173</td>
</tr>
<tr>
<td></td>
<td>22.50%</td>
<td>23.70%</td>
<td>53.80%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Exec (Clinical)</td>
<td>23</td>
<td>43</td>
<td>85</td>
<td>151</td>
</tr>
<tr>
<td></td>
<td>15.20%</td>
<td>28.50%</td>
<td>56.30%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Non-Exec</td>
<td>45</td>
<td>107</td>
<td>181</td>
<td>333</td>
</tr>
<tr>
<td></td>
<td>13.50%</td>
<td>32.10%</td>
<td>54.40%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Total</td>
<td>107</td>
<td>191</td>
<td>359</td>
<td>657</td>
</tr>
<tr>
<td></td>
<td>16.30%</td>
<td>29.10%</td>
<td>54.60%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

\[X^2(4, 657)=8.748, \ p=.068\]

In respect of perceptions of misalignment of priorities between the Healthcare Commission and PCTs, just over half (54.6%) perceive an alignment (but with the only 2.9% strongly agreeing to the alignment). In terms of the different types of directors, there is only marginal difference.
What is apparent is that 45.4% of respondents did not perceive an alignment of priorities with this key external organisation (Table 9).

c. Department of Health

The Department of Health’s influence permeates through a broad policy agenda and an ability to set explicit targets or prescribe certain forms of behaviour. Yet 45% of PCT board members either disagreed or could neither agree nor disagree that their organisation’s priorities were the same as the DoH’s. (Table 10).

Of those that report misalignment, clinical executives have the highest incidence and the non-executives the lowest. The overall message is that, as with other regulators, there is a noteworthy level of individuals who either see misalignment or cannot agree to a perception of congruence between the priorities of the DoH and the priorities of the PCT.

Table 10. Judgements about order of priorities compared to DH priorities

<table>
<thead>
<tr>
<th></th>
<th>Priorities - same as Dept of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
</tr>
<tr>
<td>Exec (Non-Clinical)</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>12.70%</td>
</tr>
<tr>
<td>Exec (Clinical)</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>16.40%</td>
</tr>
<tr>
<td>Non-Exec</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>14.40%</td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>14.40%</td>
</tr>
</tbody>
</table>

X²(4, 659) = 6.637, p = .156

d. Mixed Messages

Having noted the perceptions of board members to external regulators taken individually, there remains the question of the overall coherence of the messages/ directions/ steers of these organisations taken as a whole. Each establishes priorities within the general sphere of the PCT; meeting their demands, depends upon the overall coherence of their messages.
### Table 11. Views about mixed messages

<table>
<thead>
<tr>
<th>Priorities - mixed messages</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Exec (Non-Clinical)</td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
<tr>
<td>Disagree</td>
<td>32</td>
</tr>
<tr>
<td>Neither Agree nor Disagree</td>
<td>45</td>
</tr>
<tr>
<td>Agree</td>
<td>78</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>174</td>
</tr>
<tr>
<td>0.60%</td>
<td>18.40%</td>
</tr>
<tr>
<td>25.90%</td>
<td>44.80%</td>
</tr>
<tr>
<td>10.30%</td>
<td></td>
</tr>
<tr>
<td>100.00%</td>
<td>%</td>
</tr>
<tr>
<td>Exec (Clinical)</td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
<tr>
<td>Disagree</td>
<td>27</td>
</tr>
<tr>
<td>Neither Agree nor Disagree</td>
<td>30</td>
</tr>
<tr>
<td>Agree</td>
<td>59</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>151</td>
</tr>
<tr>
<td>0.70%</td>
<td>17.90%</td>
</tr>
<tr>
<td>19.90%</td>
<td>39.10%</td>
</tr>
<tr>
<td>22.50%</td>
<td></td>
</tr>
<tr>
<td>100.00%</td>
<td>%</td>
</tr>
<tr>
<td>Non-Exec</td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
</tr>
<tr>
<td>Disagree</td>
<td>48</td>
</tr>
<tr>
<td>Neither Agree nor Disagree</td>
<td>73</td>
</tr>
<tr>
<td>Agree</td>
<td>162</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>333</td>
</tr>
<tr>
<td>0.00%</td>
<td>14.40%</td>
</tr>
<tr>
<td>21.90%</td>
<td>48.60%</td>
</tr>
<tr>
<td>15.00%</td>
<td></td>
</tr>
<tr>
<td>100.00%</td>
<td>%</td>
</tr>
<tr>
<td>Total</td>
<td>658</td>
</tr>
<tr>
<td>0.30%</td>
<td>16.30%</td>
</tr>
<tr>
<td>22.50%</td>
<td>45.40%</td>
</tr>
<tr>
<td>15.50%</td>
<td></td>
</tr>
<tr>
<td>100.00%</td>
<td>%</td>
</tr>
</tbody>
</table>

At an overall level, a majority (60.9%) perceived a lack of coherence in the messages presented by the organisations, with 63.7% of non-executives seeing an internal incongruence in the messages received. What is pronounced is the extent to which respondents chose the extreme variant offered, with 15.5% ‘strongly agreeing’ to perceiving mixed messages from these external modes of governance. Of those that did strongly agree with the mixed messages statement, clinical executives were the most populous in their vehemence with nearly a quarter reporting conflicts in the messages (Table 11). This level of perceived confusion among PCT board members suggests a reason for some serious reservation about satisfaction with NHS governance arrangements.

If board members perceive the PCT as ensconced within a network of competing, rather than mutually supportive and sustaining, inter-organisational relations, much of their governance work consists of making a way and finding a way through a confusion of mixed messages.

### Summary

The findings of this section suggest that the reforms are seen as broadly positive and board priorities compared with other organisations are seen as generally aligned. However, although such is the majority view, there are some significant diversions from this assessment. The clinical executives exhibit a noticeably less positive assessment of the policy and institutional environment.

A picture emerges of some degree of tension between the steers offered by the network of organisations such as the SHAs and the Healthcare Commission which seek to influence board practice. This highlights the board as a sense-making site, devoted to developing responses to ambiguous, sometimes contradictory, messages. In making this sense,
governance is enacted in a participative manner, drawing in the variety of expertise in the board (although, the influence of clinical expertise is more questioned).

**4.2.3 Governance and performance**

The report now moves on to analysis at the organisational level. Part of a board’s responsibility is to develop a strategic response to the principles of the Annual Health Check. A successful board will develop an approach designed to lead to a high scores on these measures; an ineffective board may fail to monitor performance adequately, challenge itself on areas of concern, or respond to problematic issues.

Our survey developed measures of board practice in three areas:

- The extent to which the chief executive exerts control on the practice of the board
- The influence of non-executive directors
- The influence of clinicians on decisions made at the board level

The creation of organisational level indicators for these questions stems from an aggregate of individual level responses to reach a mean score per Trust. The following offers a descriptive account of the relationship between these organisational level measures and the Healthcare Commission’s composite measures: ‘Use of Resources’ (UoR) and ‘Quality of Services’ (QoS) which are rated according to the four-point ordinal scale: Weak, Fair, Good and Excellent (represented as 1 to 4 in the tables that follow).

**Board practice and HCC performance**

**i. Practice of Chief Executive**

In overall terms, the vast majority of PCTs are classed as subject to either high control (48.6%) or moderate control (42.1%) by their chief executives. Five organisations (3.6%) are classed in the very high or ‘autocratic’ category, where the chief executive is perceived to be controlling of all aspects of board practice. It is worth noting that no organisation is characterised as having very low control from the chief executive – hence this category is excluded from the analysis. We now seek to discern the association between different levels of chief executive control and overall PCT performance.

While there was no discernible pattern in the measure of quality of services, it is noteworthy that all of the Trusts in the low control category and all in the very high control category are classed in the poorer performing categories on Use of Resources (UoR) (Table 12). The results may indicate

---

4 In this section the scores derive from the 2007 Annual Health Check.

5 Healthcare Commission’s composite measures: ‘Use of Resources’ (UoR) and ‘Quality of Services’ (QoS) are rated according to the four-point ordinal scale: Weak, Fair, Good and Excellent. These are represented as 1 to 4 in the tables in this section.
that either the absence of a clear steer or its excessive deployment is related to poorer organisational performance.

The mean score for these organisations confirms this with the low and high control reporting a mean score noticeably lower than the moderate control category. This difference in means is statistically significant. A post-hoc LSD test identifies statistically significant difference between the ‘moderate control’ Trusts and all other groups (Table 13). Concerning the relatively higher performing Trusts, the moderate control group exhibits the highest relative incidence of the higher two grades of this measure (27.1%).

This pattern of results can be taken as offering endorsement for the effectiveness of the principle of board governance. When chief executives seek to exercise autocratic control, external assessments of organisational performance on effective use of resources tends to be poor.

<table>
<thead>
<tr>
<th>Chief Executive practice</th>
<th>Use of Resources (UoR)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Low control (1.50 - 2.49)</td>
<td>4</td>
</tr>
<tr>
<td>Row %</td>
<td>50.00%</td>
</tr>
<tr>
<td>Moderate control (2.50 - 3.49)</td>
<td>9</td>
</tr>
<tr>
<td>Row %</td>
<td>15.30%</td>
</tr>
<tr>
<td>High control (3.50 - 4.49)</td>
<td>24</td>
</tr>
<tr>
<td>Row %</td>
<td>35.30%</td>
</tr>
<tr>
<td>Very High control – Autocratic (4.50+)</td>
<td>2</td>
</tr>
<tr>
<td>Row %</td>
<td>40.00%</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
</tr>
<tr>
<td>Row %</td>
<td>27.90%</td>
</tr>
</tbody>
</table>
Table 13. Chief Executive control and Use of Resources Outcomes – mean scores.

<table>
<thead>
<tr>
<th>Chief Executive practice</th>
<th>Use of Resources (UoR)</th>
<th>Mean (SD)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low control (1.50 - 2.49)</td>
<td>1.5 (0.535)</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Moderate control (2.50 - 3.49)</td>
<td>2.17 (0.746)</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>High control (3.50 - 4.49)</td>
<td>1.82 (0.732)</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Very High control – Autocratic (4.50+)</td>
<td>1.6 (0.548)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1.94 (0.747)</td>
<td>140</td>
<td></td>
</tr>
</tbody>
</table>

F(3, 136) = 3.909, p = .010

ii. Influence of Non-Execs

The majority of organisations (65.7%) report this group as exercising significant influence. Concerning the Use of Resources rating, it is apparent that all of those reporting low or very low influence of Non-Execs perform in the lowest categories on this measure. The highest relative incidence of the highest two categories occurs in those PCTs reporting a ‘very high’ influence of the Non-Exec group – with 27.8% in the two highest categories (Table 14). In consideration of the mean scores for the groups the mean on this measure is higher on each subsequent increase in category of Non-Exec influence (Table 15) – although this result was not statistically significant. There is, therefore, some evidence of a positive association between non-executives influence and effective use of resources.

Table 14. NED influence and its relationship with effective use of resources

<table>
<thead>
<tr>
<th>Non-Exec influence</th>
<th>Use of Resources (UoR)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Low influence (1 - 1.49)</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Row %</td>
<td>100.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low influence (1.50 - 2.49)</td>
<td>Count</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Row %</td>
<td>25.00%</td>
<td>75.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate influence (2.50 - 3.49)</td>
<td>Count</td>
<td>11</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Row %</td>
<td>44.00%</td>
<td>36.00%</td>
<td>16.00%</td>
<td>4.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 15. NED influence and its relationship with effective use of resources – mean scores

<table>
<thead>
<tr>
<th>Non-Exec influence</th>
<th>Use of Resources (UoR)</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Low influence (1 - 1.49)</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low influence (1.50 - 2.49)</td>
<td>1.75 (0.5)</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate influence (2.50 - 3.49)</td>
<td>1.8 (0.866)</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High influence (3.50 - 4.49)</td>
<td>1.96 (0.71)</td>
<td>92</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very High Influence (4.50+)</td>
<td>2.17 (0.786)</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1.94 (0.747)</td>
<td>140</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F(4, 135) =1.109, p = .355

In terms of the Quality of Services rating, there was no apparent pattern.

iii. Influence of Clinicians

Clinicians possess levels of expertise that should feed positively into the practice of boards; this might be expected to be reflected in both effective use of resources and quality of services.

The majority of Trusts reported either moderate (45.7%) or high influence (45.0%) of clinicians. No Trusts report a ‘very low’ influence of this group, however, 7.9% of organisations report ‘low influence’.

Concerning the Use of Resources rating, in PCTs with low clinician influence 90.9% have a HCC rating in the lowest two categories (see Table 16). All of the Trusts gaining the highest ‘4’ category have a ‘high’ influence of clinicians (this category also has the highest mean score of any other
group). This finding could suggest support for the principle of ensuring effective clinical voice on PCT boards.

Table 16. Clinician influence and effective use of resources

<table>
<thead>
<tr>
<th>Clinician Influence</th>
<th>Use of Resources (UoR)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Low influence</td>
<td>Count</td>
</tr>
<tr>
<td>(1.50 - 2.49)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
<tr>
<td>Moderate influence</td>
<td>Count</td>
</tr>
<tr>
<td>(2.50 - 3.49)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
<tr>
<td>High influence</td>
<td>Count</td>
</tr>
<tr>
<td>(3.50 - 4.49)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
<tr>
<td>Very high influence</td>
<td>Count</td>
</tr>
<tr>
<td>(4.50+)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
</tbody>
</table>

In terms of Quality of Services, the distribution of the data does not display an obvious or meaningful pattern. We might hypothesise that quality of services might be reflective of broader clinical influence in the operations of the Trust, rather than reflective of influence at the board level.

Summary

A link has been indicated between the performance measure effective Use of Resources and various aspects of board working. Whilst a moderate-strong chief executive appears to be associated with higher levels of performance, there are indications that excessive control may be associated with diminished performance. It seems, therefore, that whilst a strong steer from the top is valuable, one which bypasses governance (understood as a participative deliberative process) has a negative effect. There is also evidence that Non-Exec influence is associated with positive performance and evidence too of a positive influence of clinicians.

This pattern of findings offers endorsement of an effective model of governance where all groups participate and influence decisions. External assessment of good performance is associated with our independent and separate measures of PCT governance.
4.2.4 Governance and organisational performance using multivariate analysis

This section broadens the discussion by adopting an augmented set of governance measures at the organisational level. The organisational level data set, consisting of eleven variables, contains a variety of indicators aggregated from individual question responses expressed in terms of the mean response per organisation as well as a series of theoretically informed composite measures of aspects of governance.

In order to investigate the relationship between this set of variables and performance measures such as the Annual Health Check ratings it would appear quite natural to use multiple regression analysis. Here the performance measure would appear as the ‘dependent variable’ with the eleven organisational level variables as ‘independent variables’. This approach is compromised by two issues:

- the ordinal nature of the performance measures;
- multicollinearity amongst the organisational level variables.

In principle, the first issue could be dealt with by using techniques such as multinomial logistic regression or ordinal regression. However, neither of these is suitable in this case. Multinomial logistic regression would regard the performance measures as (unordered) categories thus sacrificing the information conveyed by the ordering. Ordinal regression would be an interesting alternative but unfortunately its data demands simply can not be met with a data set consisting of 140 or so PCTs. In these circumstances the use of multiple regression seems justifiable if carefully interpreted.

The second issue is more easily dealt. Naturally we are interested in examining any underlying structure within the dataset of organisational level variables. In order to examine the inter-relationships amongst these variables, we enter them into a Principal Components Analysis (PCA). As shown in the Appendix the eleven organisational level variables can be represented by four principal components interpreted as representing the following ‘themes’ within the data:

- C1: Positive attitude towards the usefulness and relevance of the Annual Health Check
- C2: Alignment of executives, non-executives and clinicians / service emphasis
- C3: Chief executive runs the show
- C4: Finance emphasis

Importantly, these components are uncorrelated and we now use these rather than the eleven variables in regressions against the various

---

6 A full description of these variables is given in the Technical Appendix.
7 A full description of the analysis and components is given in the Technical Appendix for this Chapter.
performance measures. Initially we use the ratings from the 2007 and 2008 Annual Health Checks. The results for Quality of Services are not reported here as with the exception of C1 (Positive attitude towards the usefulness and relevance of the Annual Health Check) no other components are significant. The results for Use of Resources are shown in Table 17. A tentative conclusion, after again noting the significance of C1, is that there is a tendency for C2 (Alignment of executives, non-executives and clinicians / Service emphasis) to associate with better performance and C3 (chief executive runs the show) to associate with poorer performance.

Table 17. Use of Resources ratings in the 2007 and 2008 Annual Health Checks regressed against four components.

(a) 2008 – $R^2 = .079$

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>2.507</td>
<td>.054</td>
<td>46.243</td>
</tr>
<tr>
<td>C1</td>
<td>.142</td>
<td>.054</td>
<td>.218</td>
<td>2.624</td>
</tr>
<tr>
<td>C2</td>
<td>.094</td>
<td>.055</td>
<td>.143</td>
<td>1.716</td>
</tr>
<tr>
<td>C3</td>
<td>-.005</td>
<td>.055</td>
<td>-.007</td>
<td>-.083</td>
</tr>
<tr>
<td>C4</td>
<td>-.066</td>
<td>.054</td>
<td>-.102</td>
<td>-1.221</td>
</tr>
</tbody>
</table>

(b) 2007 – $R^2 = .111$

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>1.938</td>
<td>.061</td>
<td>31.615</td>
</tr>
<tr>
<td>C1</td>
<td>.161</td>
<td>.061</td>
<td>.214</td>
<td>2.623</td>
</tr>
<tr>
<td>C2</td>
<td>.116</td>
<td>.062</td>
<td>.154</td>
<td>1.877</td>
</tr>
<tr>
<td>C3</td>
<td>-.140</td>
<td>.062</td>
<td>-.184</td>
<td>-2.250</td>
</tr>
<tr>
<td>C4</td>
<td>-.067</td>
<td>.061</td>
<td>-.090</td>
<td>-1.098</td>
</tr>
</tbody>
</table>

We now consider additional measures of performance by incorporating data from a recently published league table of PCTs in respect of ‘World Class Commissioning’. This league table is constructed from four measures where three of these relate to governance: ‘strategy’, ‘finance’ and ‘board’ each of which is rated ‘green’ (2 points), ‘amber’ (1 point) or ‘red’ (0 points). These so-called ‘traffic light ratings’ are added to provide a score between 0 and 6 which serves to divide the Trusts into seven ordered groups. The fourth measure is a ‘total competency score’. This is used to provide a ranking within the seven groups. In other words this World Class Commissioning league table is a lexicographic order in which the total governance traffic light score is prioritised above the total competency score.

⁸ Crump, H. 2009, PCTs exceed expectations in year one. Health Services Journal, 5 March 2009, [www.hsj.co.uk/pcts-exceed-expectations-in-year-one/2001726.article]
Obviously the league table position depends on the other two scores which, however, can be seen as independent ratings of the performance of the PCTs. Table 18 shows the results when the ‘traffic light score’ and the ‘total competency score’ are regressed against the four components. The most noteworthy feature here is the positive, and highly significant, role for C2 (Alignment of executives, non-executives and clinicians / service emphasis) in both measures. The only other significant coefficient is C1 (Positive attitude towards the usefulness and relevance of the Annual Health Check) for the ‘traffic light score’.

Table 18. World Class Commissioning scores regressed against four components

(a) Traffic light score – R² = .125

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>3.953</td>
<td>.116</td>
<td>34.112</td>
</tr>
<tr>
<td>C1</td>
<td>.262</td>
<td>.115</td>
<td>.187</td>
<td>2.278</td>
</tr>
<tr>
<td>C2</td>
<td>.396</td>
<td>.116</td>
<td>.281</td>
<td>3.424</td>
</tr>
<tr>
<td>C3</td>
<td>.029</td>
<td>.117</td>
<td>.021</td>
<td>.250</td>
</tr>
<tr>
<td>C4</td>
<td>-.143</td>
<td>.115</td>
<td>-.103</td>
<td>-1.250</td>
</tr>
</tbody>
</table>

(b) Total competency score – R² = .091

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>16.574</td>
<td>.202</td>
<td>81.932</td>
</tr>
<tr>
<td>C1</td>
<td>-.012</td>
<td>.201</td>
<td>-.005</td>
<td>-.057</td>
</tr>
<tr>
<td>C2</td>
<td>.699</td>
<td>.202</td>
<td>.289</td>
<td>3.460</td>
</tr>
<tr>
<td>C3</td>
<td>.034</td>
<td>.204</td>
<td>.014</td>
<td>.167</td>
</tr>
<tr>
<td>C4</td>
<td>-.200</td>
<td>.200</td>
<td>-.083</td>
<td>-.998</td>
</tr>
</tbody>
</table>

Alongside the significance of C1 (Positive attitude towards the usefulness and relevance of the Annual Health Check) in almost all these results, a common thread is the positive role of C2 (Alignment of executives, Non-executives and clinicians / Service emphasis), a feature shared with the analogous component for the acute dataset where the coefficient is always positive if not significant. There is also a hint, much less assertive than in the acute dataset, that C3 (chief executive runs the show) associates with poorer performance (see Table 17(b)).

Summary of findings from the PCT survey

Summary of findings from the PCT survey

9 The more ambiguous role for this component is perhaps not too surprising. Unlike the Acute dataset the loading of ce_rts is not combined with a reversed loading for neds_strong and there is also, perhaps, a confounding influence arising from the loadings of oth_dir and pol_coh.
Using this wider set of variables and subjecting them to multivariate analysis there are again some suggestions of association between governance and effective use of resources; there are no apparent links between governance and performance in respect of the QoS score.

The analysis additionally shows a positive relationship between board performance and the exercise of strong influence by NEDs and their internal alignment with other key actors on the board. However, there are indications that where there is very assertive behaviour by the chief executive, this has an opposite effect; we may hypothesise that such action could undermine the participative quality of the collective act of governance and thereby impact adversely on board performance.

The WCC data enables a broader view of performance than that restricted to the Annual Health Check ratings. Here, again, the positive role of internal alignment and influence is repeated offering further credence to the view of the desirability of balanced and participative governance in enhancing organisational performance.

### 4.3 Summary and Conclusions about PCT Governance

From the postal survey the practice of PCT boards can be seen as a site of sense-making with a policy and institutional context that carries elements of ambiguity, tension and contradiction. Boards are not simply faced with distributional challenges. PCT boards, the survey evidence suggests, draw from the range of sources of expertise available to them. The evidence suggests that the NEDs play an effective role and do make a difference. Likewise, boards seem to work best when chief Executives are not too dominant. Correlations with various assessments of organisational performance indicate that this mode of governance has a positive role and effect. Performance is best when boards function in a participative and balanced manner allowing different groups appropriate influence.

Governance, understood as a participative and collective act is shown to be associated with higher performance.

These findings both complement and conflict with those from the case studies reported earlier. The tension between executive directors imbued in the workings of the NHS and the NEDs anxious to bring fresh thinking to governance was evident in both the qualitative and the quantitative data sources. The interview data enabled richer insight into the nature of the hesitations and critiques which the NEDs brought to bear. Likewise, the critical stance taken by clinicians and revealed in the survey data was made clearer in the case studies.

These and related findings and conclusions are developed in a deeper way in the concluding chapter of this report.
5 Findings about the Governance of NHS Acute Trusts

In this section we turn to a presentation of findings about governance in the acute trusts – both Foundation Trusts and NHS (non-Foundation) trusts. We begin with the distinctive features of the Foundation Trusts and their practical workings. Table 19 shows a summary profile of the acute trust case studies.

Table 19. The Six Acute Trust Case Studies

<table>
<thead>
<tr>
<th>THE SIX ACUTE TRUST CASES</th>
<th>LOCATION/CHARACTERISTICS</th>
<th>PROFILE 2007/8</th>
<th>FT OR NON-FT</th>
<th>KEY GOVERNANCE FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. London Foundation Trust Case A</td>
<td>London Large teaching hospital</td>
<td>&gt; £550m turnover. 6,300 staff 450,000 inpatients; 500,000 outpatients</td>
<td>Foundation</td>
<td></td>
</tr>
<tr>
<td>2. London Foundation Trust Case B</td>
<td>London Large teaching hospital</td>
<td>&gt; £500m turnover &gt; 6,000 staff &gt; 400,000 i/p &gt; 450,000 o/p</td>
<td>Foundation</td>
<td>6 NEDs (inc Chair) 5 Exec Directors + 3 non-voting directors attend Board meets monthly</td>
</tr>
<tr>
<td>3. Midlands NHS Trust</td>
<td>Midlands</td>
<td>£170m turnover 3,500 staff 60,000 inpatients 250,000 o/patients 620 beds</td>
<td>Foundation</td>
<td>12,000 members Board of Governors SBU with P&amp;L accountability</td>
</tr>
<tr>
<td>4. North NHS FT</td>
<td>North of England</td>
<td>£270m 8,100 staff 45,000 inpatients 95,000 o/p 155,000 A&amp;E</td>
<td>Foundation</td>
<td>Monthly boards held in public Business Units structure Board Development Programme Board of</td>
</tr>
<tr>
<td>5. South NHS FT</td>
<td>South of England</td>
<td>&gt; £160m &gt; 3,500 staff &gt; 80,000 inpatients &gt; 70,000 A&amp;E attendances &gt; 600 beds &gt; 350,000 local popn.</td>
<td>NHS Trust (became Foundation during the study)</td>
<td>9,000 members</td>
</tr>
<tr>
<td>6. Midlands</td>
<td>Midlands</td>
<td>&gt; £160m &gt; 2,500 staff &gt; 600 beds</td>
<td>NHS Trust (became Foundation during the study)</td>
<td>8,000 members</td>
</tr>
</tbody>
</table>

### 5.1 The Key Issues

NHS trusts which have not yet gained Foundation Trust status, continue to be answerable to their SHAs. Although they have boards of directors their governing capacity is thus significantly curtailed. In contrast, Foundation Trusts as semi-autonomous devolved bodies, freed from direct control by SHAs and governed by boards and by members councils, ought to reveal even more accentuated aspects of governance than was the case with other acute trusts or with PCTs. FTs are supposed to be accountable to their local communities through their members and governors. As devolved bodies, Foundation Trusts are expected and indeed required to operate with diverse lines and types of accountability. These include remnants of traditional hierarchical accountability to the Department of Health, contractual...
accountability to commissioning bodies, accountability to regulators, partnership accountability to agencies such as local authorities and local accountability to governors, members, patients and the public. These types of accountability are mapped in Figure 3 and Figure 4 for NHS Foundation Trusts and for NHS acute trusts respectively.
Figure 3. Foundation Trust Accountability Map
Figure 4. Acute Trust Accountability Map

Key
- Hierarchical report
- Regulator report
- Contractual
- Partner accountability
These figures are a magnified segment of the more schematic diagram of
NHS governance shown in the Introduction to this report. As we will
endeavour to show in this section of the report, part of the work of
governance undertaken by the boards of FTs is to balance accountability to
a number of different regulators and stakeholders.

The Department of Health’s (2002) Guide to Foundation Trusts stated
clearly that Foundation Trusts are designed to ‘introduce a new form of
social ownership where health services are owned and accountable to local
people’. In practice, we found that this notion of accountability to local
people to be problematic.

Failings in clinical standards are increasingly likely to be seen as connected
with failings in governance. For example, Mid Staffordshire Foundation Trust
received an adverse Healthcare Commission report which was sent to the
Governors of the trust. This prompted the resignation of both the Chair and
the Chief Executive. Monitor quickly intervened to appoint replacements. A
letter from Monitor to the trust’s governors said it was likely to highlight
"inadequacies in aspects of the quality of clinical and nursing care at the
trust, alongside broader governance and senior management failings". It
was prompted by high mortality rates, particularly in emergency
admissions.

We begin the analysis with the Foundation Trust Board, next we proceed to
assess the significance for governance of the member’s councils, and we
then turn to the accountability of FT boards to various bodies using the
framework of the different types of relationships (vertical, horizontal,
diagonal, and contractual) as discussed earlier.

5.1.1 Foundation Trust Boards

Unlike the original NHS trusts, the Chair and NEDs are appointed by, and
can be removed by, boards of governors (see below). These boards (often
also known as members councils) are made up of a mix of elected members
(representing the public, patients and staff) and appointed governors
(representing PCTs, local authorities and other local organisations). In turn,
the Chair and the NEDs appoint (and can remove) the Chief Executive with
the approval of the board of governors. Thus, at least in formal terms, the
governance arrangements for Foundation Trusts are clear – there is a
unitary board which is accountable to a board of governors. Most notably, in
formal terms at least, vertical accountability to the Department of Health or
SHAs has been removed. Foundation Trusts maintain some public
accountability to parliament but this is limited to the setting of accounts
before parliament.

The Role of the Chair

The Chair of an FT is potentially a very significant role. According to the
legislation the chair of the trust board is also the chair of the board of
governors. Many of the chairs we studied were very powerful and influential
individuals. One of them commented:
I see my role, as Chair, as running the board; the Chief Executive’s role is to run the organisation. I am clearly instrumental in recruiting the Chief Executive and I believe I can, and have been instrumental in helping that management team, that executive team, create the ethos of the organisation. (Chair of an FT in the Midlands).

This statement reflected many other similar observations by chairs in the case studies and the wider panel of interviews. Chairs tended to regard themselves as guardians of the principle and the idea of trust governance. They almost invariably argued that governance through the boards was an absolutely crucial factor in the success or otherwise of these trusts. With regard to the way of exerting such an influence the next quote from another Chair offers a useful insight:

There are all sorts of ways of running a board, and I believe the Chairman is in the unique position of steering which way that board is run ... for every Chairman there needs to be a good period of reflection about, hang on a minute, how do I really want to run this board? In my view it is about balance between dilemmas – one aspect of this is the balanced engagement between strategy and operations. There are many boards that can’t get their nose out of the engine room and get themselves too immersed in operations. And there are many other boards that are too intuitive, they’re too much in the skies with their strategy and not enough about on the ground (Chairman, Southern FT).

In the light of these kinds of claims it follows that board and Chair development is an important issue. In general the case studies suggested that some form of board development was commonplace but equally there was also a view that, so far, not quite enough of it is done at the right level of quality.

Finally, chairs were found in the main not to be properly assessing the performance of executive directors as board members. When asked, most executive directors report that the chief executive takes on this responsibility for the executives, leaving the chairs only to review the NEDs.

The Role of the Chief Executive

Chairs, NEDs and other executives notwithstanding, Chief Executives tend to be the key figures on FT boards. A new CEO of an FT observed:

One of the issues for me about this organisation is that most of the top team, non-execs and executive directors, are involved in delivering operational excellence rather than contributing to strategy. That division of labour, for me, isn’t right. The partnership between the Chairman and Chief Executive is also an interesting one here. The arrangement, I think, that the Chair had with the previous Chief Executive was that the Chair did most of the outside stuff and the Chief Executive most of the inside stuff, again, this will not work for me (FT Chief Executive, Midlands).
The multiple and diverse priorities for a Chief Executive and the related problem of understanding what counts as ‘success’ is captured nicely in the following observation:

*Take the real position we’re in today. We are running at least one medical ward more than we planned to run. So, we’re spending more money than we planned to run. I haven’t really looked at beds in my elective services. So, I’m struggling with waiting lists, I’m struggling in A&E, I’m struggling on finance, yet I’m earning a considerable amount of money especially in the last 5 months with the additional patients we’re treating. Is that good or bad? (FT Chief Executive, North)*

Another key role of the CEO is to build relations with a range of stakeholders. Keeping Monitor satisfied and the (then) HCC satisfied is a key part of this. But there were also signs of confusion regarding appropriate relations with PCTs and SHAs. Some chief executives adopted a bullish stance in relation to each of these bodies. They wanted to assert their independence as commercial entities. But for others there were signs of attempts to manage collaborative relations with PCTs and with community services:

*I see it as part of my brief to build a relationship with my external stakeholders, one group of which are my external commissioners. So, this afternoon, for example, I’m going down to see the Chief Executive of [...] PCT to say “You’re overheating your contract by several hundred thousand pounds, you and I need to understand what that means for both of us”. My job is to deliver the contract. They expect me to deliver my contract, not deliver their contract plus two or three million pounds. The agreement is, as far as I’m concerned, to do what we’re contracted to do.*

*Because I’ve got a plan for this year based on a required number of patients coming to the organisation that we treat which gives us an overall surplus of timing effects. Happy with that, thank you very much. If the patient flow starts to change, I have to change my plan quite radically. A couple of thousand pounds here and there is not a problem for me, not a problem for the PCT. If it’s two or three million pounds, they can’t then afford to buy the elective care they need to buy, I haven’t got the beds to put the patients in, then we become more inefficient and those patients get treated elsewhere. It breaks down the trust between provider and contractor (Chief Executive, South Central FT).*

Another FT CEO emphasised this crucial dilemma arising from FT status – to focus on the business as a separate unity or to consider the wider NHS?

*I think at the moment the main, the big pressures, are financially driven, so in our health economy we have PCTs with debts, I guess in some other health economies it’s the trusts that have the debt, but most health economies have got debt somewhere I know, and so that’s not sustainable, is it? So there’s got to be a method of addressing that as a*
whole health economy. As a Foundation Trust that’s stretched us a bit about how much do we do for the corporate good of the NHS.

I have to say Foundation Trusts, I think, have been given almost an unfair advantage over NHS trusts. We’ve left a system that is very command and control, and top slicing decisions of organisations. Nobody can do that with a Foundation Trust, and we have to be paid for the work we do by a national tariff and payment by results has really helped us.

The two main PCTs who commission from us are in deficit and it’s not sustainable, inevitably the payment by results and other factors are going to force PCTs to get a better grip on demand, we would accept that there are patients that have been hospitalised that in other communities with better primary care and primary care infrastructure, they wouldn’t need to be hospitalised. I think it only sensible that we sit down together and work a way through these issues.

There were also attempts to build bridges between FTs and PCTs using clinicians: “We’ve had what we call the Joint Clinicians Board, and that’s Chaired by our Medical Director, PEC members from the two PCTs attend and a practice-based commissioner and our clinical directors, and that’s been reasonably successful. I think the doctor relationships have always been reasonable. It’s the management relationships which have been getting rocky because of the system, because of the financials, because of the parent-child behaviours that sometimes go on’.

Overall, there were two main types of chief executive when viewed from a governance perspective. One group remained attached to the idea of the chief executive as leader, and moreover, tended to see leadership as the crucial factor. From this standpoint, governance and non-executive directors were at best to be tolerated as a necessary sign of conformance to external accountability concerns, at worst they were regarded as a bit of a nuisance which required ‘managing’. A second group of chief executives welcomed the infrastructure of board governance and set-out to use it in a positive manner. This meant encouraging the appropriate forms of challenge to executive directors meant also an opening up of the horizon of possibilities to fresh thinking from the commercial world; and meant openness to new techniques, frameworks and ways of working appropriate to board-level work. In other words, these chief executives wanted to learn and were also willing to share accountability with a board. The proportion of chief executives falling into each of these camps across the country is shown later in this chapter when we report on the findings from the national postal survey. In addition, we reveal the performance outcomes associated with those modes where chief executives seek to ‘run the show’ compared with those modes where chief executives seek to promote board governance.

The extent to which the positive approach to governance could be realised in practice depended very much on the capabilities and behaviours of NEDs and it is to this group of actors in governance that we now turn.
The Role of the NEDs

It was suggested to us that the Appointments Commission and Monitor due diligence process had 'weed out' ineffective NEDs and also relocated those with only community knowledge into the board of governors. This, in theory, allowed recruitment of a high performing group of NEDs with business and professional (legal, financial, marketing) acumen. But on the downside, in many cases, these new NEDs had limited experience of the NHS or public services. This, even with FT freedoms, caused frustration with the politics and bureaucratic systems and forms of regulation which remain in this sector.

NEDs tended to argue that their impact was especially high in areas such as the Audit Committee, the Finance Committee and the Remuneration Committee. Their priorities tended to be sound governance and effective risk management as standard practice and then to move on to more sophisticated strategic management. They also tended to think and talk in terms of markets and market segments. There was some tension mentioned by a number of them with regard to a degree of 'frustration' about how circumscribed their role and that of the board was felt to be. A large proportion reported that in practice the Chief Executive presented the board with lists of targets, and standards deriving from outside which were inescapable priorities. This led some NEDs to observe that trust board felt more like subsidiary boards than 'proper' corporate boards. Given these restrictions some NEDs argued that their longer-term role was to 'change the culture' in the NHS – for example, by instilling a new attitude to risk and its mitigation. In part they saw this as starting with board development and changes to board behaviours.

Crucially, many NEDs were not properly involved in shaping trust strategy; rather, they were essentially faced with a fait accompli in many instances. Moreover, their induction programmes were often provided long after they had started their work on the board and they found the guidance notes unnecessarily 'long winded' and imprecise about the role and the responsibilities.

In terms of demographic profile, the non-executive directors in our case study trusts ranged from young, child-caring females to retired, male ex-private sector finance directors of major companies. There were of course many points in between, with solicitors, local councillors and others also represented. In recent years, the tendency however has been towards greater numbers of NEDs with commercial and especially financial experience. Undoubtedly, part of this trend has been prompted by the drive towards FT status – a number of our case study trusts had been advised during their diagnostic phase when preparing their FT applications that they needed more business acumen and experience on their boards.

Officially, NEDs are notionally meant to spend about two and a half days a month on their duties; in practice virtually all NEDs in each of the cases said they spent at least double that. An acknowledged part of the problem was seen as the complexity of the NHS and the difficulty in coming to terms with
that. This raises the issue about what a realistic governance role for NEDs really should be.

Some NEDs perceived their role to act as ‘representatives’ of various constituencies – either patient groups such as cancer patients or community groups such as various ethnic minority or religious groups. Others were looking for corporate level challenge and leaned towards an interpretation of the Foundation Trust as a commercial venture with a need for market positioning and sound finances.

While NEDs were familiar with, and supportive of, the idea of ‘integrated governance’ and thus wanted to include issues of the patient experience and of clinical quality alongside matters of finance, it seemed that in practice they primarily focused on the latter for most of the time. It was routine in each of the case study trusts for a ‘dashboard’ of performance indicators to be considered at each board meeting but, in practice, we observed that almost invariably executive directors had ready explanations for the pattern of data including the red-marked highlights using the ‘traffic light’ system and NEDs were rarely able to influence or contribute further to these areas.

A number of the NEDs argued that they were more representative of the longer-term interests of the trust because they were ‘local’ direct stakeholders and they contrasted this with the executive directors whom they sometimes depicted as career ‘NHS civil servants’ who were more mobile and who in any case tended to reside some distance from the trust site or sites. Such a characterisation unfair as it might have been does indicate an interesting slant on the need for and the role of governance.

The optimistic view, argued by some NEDs, was that their executive director colleagues had already progressed in their business understanding as a result of their interaction with more sophisticated and knowledgeable NEDs following FT status. However, a point of concern expressed by some NEDs was about the confidence they could have in really understanding what was happening at the operational level in their trust. One device used by some of the cases was to link each NED with a particular clinical directorate so they could get to know the general managers and the clinical directors.

**The Role of Governors and Members in Foundation Trusts**

While the overall level of accountability was low there was some considerable variation in the operation of ‘members’ and their board of governors (or members councils). The governing boards were given a variety of names – most commonly ‘members councils’ – this shift in nomenclature seemed to signal quite strongly that their role was not to ‘govern’ but to advise. We found considerable uncertainty and ambiguity expressed by the governors we interviewed and indeed more than a degree of dissatisfaction. Some of them had originally applied to be non-executive directors. These were often experienced professionals who had previously held senior positions in commercial enterprises. They expressed disappointment at the lack of clarity and indeed influence they had experienced in their new role.
‘To represent the local community’. The idea here was that they would as a group be accepted in broad terms as defenders of the community interest and indeed of the values of the NHS. A fear held by some executives and indeed by some chairs was that Governing bodies might be infiltrated and taken-over by special interest groups – perhaps pursuing a narrow medical agenda or a political agenda. As one Chair said: “We have to be watchful that the whole thing is not taken over by the Trots or some similar faction. With low active participation rates, it would not take much effort to bring this about”. Policy makers had considered the option of boards of governors as similar to the supervisory boards in German companies and to accord them decision-making powers. This would have required boards with maximum membership of about 12. This option was abandoned: no upper limit was placed on membership and it became clear that the role was to be advisory rather than carrying any kind of veto.

We did a calculation of the number of Governors per FT in early 2009 when there were 114 FTs authorised by Monitor. We found that the mean number of governors per trust was 33. There was a range from highs of 69 (Northumbria Healthcare NHS Foundation Trust) and 55 (Tees Esk and Wear Valleys) and lows of 19 (City Hospitals Sunderland) and 21 (North West Royal Hospital). The standard deviation was 7.7 reflecting some considerable bunching around the mean and yet also some significant variation. The mean average of 33 does indicate that trusts have opted for some kind of representative model rather than a strategic supervisory board.

There appears to be some ambivalence among chief executives and chairs about the legitimacy and effectiveness of boards of governors. One FT Chair suggested that the accountability of Chief Executives to the governing boards was not something that was always welcomed.

> It was a hell of a cultural shock for some of the chief executives, they thought they were going to get free of the Department of Health, go off and run the organisations exactly how they want, basically be accountable to nobody. And they suddenly find that they’ve got an elective [sic] body which has the power to remove the majority of the board. This is not something many chief executives find comfortable.

But, the case for a strong accountability role for the governing boards was made by the same FT Chair:

> Accountability of the board of directors to the governors is one of the things that I insisted on in the legislation actually. A group of us - as Chairmen - said "If you set these things up so that there is no way in which the governing body can actually control the board, then you have got a serious problem because boards will just do what they like".

By removing the vertical accountability to the Department of Health and Secretary of State there was a danger of an accountability gap. The governing boards are supposed to have addressed this. During our interviews both sets of office holders sometimes expressed concern about
the effectiveness and ability of local people and an elected board to hold a Foundation Trust Chief Executive and Board to account.

Lewis and Hinton (2008) in a study of one Foundation Trust described the governors as “toothless tigers” (2008:23). They went on to observe that “The intended relationship between governors and the board of directors is subject to a more subtle balance of power - governors must be listened to, but cannot dictate policy; the board is empowered to run the hospital but the Chair and non-executive directors can be dismissed by the governors” (Lewis and Hinton 2008: 24). Such equivocation about the exact nature of the relationship with governors was reflected in our interviews with governors. They judged that they are easily controlled by chief executives and boards of directors and in general they don’t have the information they need to fulfil their role of account-holder. As one Governor said: ‘We don’t seem to be given the necessary information ahead of time to allow us to make any serious decisions’.

But there is another view that the governors at least have the potential to exert strong accountability. As one FT Chair argued:

They could be very powerful. They choose the chairman and they choose the non-executive directors and the chairman and non-executives are a majority of the board. Now there’s a problem because, you know, you can have the man in the monkey suit elected as Chairman so you’ve actually got to manage the process so that that doesn’t happen. And you need to maintain a board that’s going to be effective rather than one that’s going to have either the local political activists on it. That could happen, we can’t stop that happening.

Given the importance of this vertical accountability relationship which replaced accountability to the Secretary of State, it is surprising that these issues remain unresolved and that chairs and chief executives are still somewhat ambivalent about whether this is working effectively as a form of accountability.

In terms of the composition of the Governing bodies, some trusts had separated out stakeholder groups more than others. Aintree University Hospitals, for example, had 14 public governors, 5 staff governors, 3 patient governors and 9 nominated governors (mainly local authority representatives).

If we now turn to the findings from our case study interviews, we can shed some light on the crucial question about how in practice board directors viewed the role of governors and how governors themselves evaluated their roles. We discovered that, in the main, they were not perceived by board directors to exercise power, rather their role was expressed by directors using term such as ‘influence’, ‘sounding board’ ‘ambassador’, or allowing ‘voice’ to the local community. But, even the degree of ‘influence’ was uncertain. Notably, unless directors (both executive and non executive) were being explicitly asked about the governors and members then these roles were rarely mentioned as playing any significant part. For example, in
response to a question about limits on room for manoeuvre for strategy, the governors would usually not be mentioned at all.

The chairs of the boards of directors were also the chairs of the governors. This was mandated in the regulations for Foundation Trusts. However, some governors were unhappy with this arrangement as they were uncertain whose interests the chair was representing – was it the governors or was it the board of directors?

The board meetings were in the main restricted to three or four per annum. We observed the four such meetings using a systematic data recording sheet. It was evident in each case that the meeting was driven and controlled by the chair and board directors who were present. In three of the observed cases the directors sat together at the front and the governors sat facing them as an audience. The number of governors present in these members council meetings averaged about 50. There was little scope for much meaningful interaction. The agendas were managed by the board secretary and chair and the pattern was for the directors to present a series of reports to the governors. These included performance monitoring reports involving traffic light tabulations. The general tone in each case was one of reassurance. Governors occasionally asked a few polite questions and the directors responded with assurances that the matter had either been dealt with or was in the process of being tackled. Our conclusions were that in the main governing bodies were adopting, or had been manoeuvred into, a relatively passive role.

The DH was intent from the outset that governors should not be involved in operational matters but should be addressing aspects of strategy. The distinction is rarely clear cut and our findings suggest that governors are interested in certain aspects of operational matters if this is understood to include infection rates, cleaning regimes, car parking, waiting times and similar performance matters.

Given the uncertainty about the representativeness of elected governors it is hard to argue that they can be legitimately seen as the authentic voice of the community or to speak with any substantial mandated authority. Equally, their role in communicating outwards and explaining – and defending – the trust’s stance to the wider patient community and public appears to fall short of expectations. The chief executives we interviewed expressed a desire for them to take on this role but it was only partially being adopted apart from one or two notable instances where individuals were willing and able to act as champions for the trust.

Patients and members of the public (living within a trust locality) have to opt-in to ‘membership’ of the FTs. Typically persons over the age of 14 can be members. But how many members should an FT have? FTs are required to actively recruit ‘members’ who in turn elect the governors. There is no stipulated minimum number of members though in practice each trust on average seems to recruit a few thousand each. It was suggested to us that while Monitor was originally taking an interest in that question that it had now relaxed its gaze on that front. One FT chair observed:
My own thinking is that to claim we are really representing the population we serve we need at least 10% of that population as members. In our case that means we need at least 40,000 members, but at the moment we only have 8,000.

An analysis by Monitor of the first 20 Foundation Trusts found that the proportion of members actually voting in Governor elections were on average between 40% to 60% depending on the trust in question. This kind of proportion is rather respectable being higher on average than local government elections. Monitor has not repeated this analysis in the intervening years though it told us that it intended to collect such data later in 2009. A typical membership list for an FT is between two thousand and four thousand members. University of Birmingham Hospitals proposed to tier membership according to their levels of interests. Level 1 members (estimated to be the majority) would just receive an annual newsletter, Level 2 members would receive quarterly reports and some key documents; Level 3 members (around 10% of engaged members) would receive each of the above plus participation in seminars and other modes of involvement.

The first wave FT who had experience extending over 3 to 4 years still seemed to contend that they were in learning mode and that they had underestimated the amount of time and effort required to make members and governors into a presence that could genuinely make a difference. This in turn implies that the public accountability dimension of Foundation Trusts remains very much open to question.

**Breaking free from the SHA**

Foundation Trusts are not directly accountable to the Secretary of State and are therefore not overseen by SHAs or the Department of Health. Instead they are authorised and regulated by Monitor. The playing out of these new relationships has revealed a number of challenges. The most evident of these has been the public struggle between the NHS Chief Executive and the Executive chairman of Monitor about the legitimacy of directives and control from the Department to the FTs. This incident has been indicative of an ongoing uncertainty about the extent to which the FTs can really assert their independence from their former masters in the shape of the SHAs. From our interviews it appears that the relationship with the SHA continues to operate informally in many cases.

Interviewees were conscious of the history of the relationship with SHAs and regions. There was a view that the trusts were to have devolved power and the SHAs to operate at a different level and with a different strategic remit rather than a direct control. But, as one Chair observed “Then, certain trusts and PCTs started to overspend and all of a sudden the Department of Health said, hang on a minute, this is getting out of control. You SHAs should sort it. But then they said, well excuse me, but we’re not supposed to. So the rules were changed again and the tide of decentralisation started to go back to a centralisation again”. Respondents seemed used to dealing with these fluctuations in accountability.
One Chief Executive of an FT was clear that the SHA continued to try to hold on to a governance role: “they [SHAs] should be off our back, but they still like to have a little dabble now and again!” Another Chair of an FT felt the SHA had not got the message that Foundation Trusts were supposed to be more autonomous.

This is where I need to say that when the Foundation Trusts were formed we were given a very clear steer from Monitor that it’s all changed and ... Monitor was the regulator, and we were in inverted commas, ‘independent Foundation Trusts’. Now the SHAs either didn’t look down the telescope or didn’t get the message. Because they continued, generally speaking, certainly in our case, as if nothing had happened.

And kept on sending out enquiries about how we were getting on and what we were doing and whether we were up to this or up to that, and so on and so forth. And we operated a policy in the first couple of years of being a Foundation Trust of sending these surveys and requests, ‘Return to Sender’. We have amended that policy now and within reason we seek to work with them.

The creation of Foundation Trusts has also radically changed the role of the SHA as account-holder. From the perspective of those we interviewed in SHAs the lines of accountability have become even more complicated than they were, making the job of SHAs more difficult than in the past. A current SHA Chief Executive observed:

When I was a Regional Director all the trusts were accountable to us in a linear fashion, now, from here, it just feels 180 degrees different. It is far more complicated, far more nuanced, and far more reliant on encouragement and coercion. ... We have a strong group of Foundation Trusts, all of whom want to work with the system, but all of whom also want their independence. So on any issue, you’re trying to herd the cows and I think we’re still learning how to do it. [SHA Chief Executive]

From an SHA perspective the task is to balance independence with responsibilities and accountabilities. While FTs are no longer formally accountable to SHAs, they are still significant actors in the NHS regionally and therefore, in the SHAs’ view at least, have some obligations. The following quote suggests that the extent of independence enjoyed by the FTs is not yet settled. One SHA Chief Executive stated:

The deal I’m trying to create is that the FTs, and ultimately I suppose, the big independents have a legitimate seat at the table, they are major representatives of the healthcare industry helping to craft the system. Clinically, as well as managerially, there’s a right to sit at the table, and decide the future. In return for that right there’s a responsibility which says, you have to recognise that there will be an equity of opportunity and quality across the region, that decisions on standards will be made region wide, and that you need to not compromise your independence, but recognise the degree of interdependence. [SHA Chief Executive]
But SHA chief executives as a group are well aware that part of their role is to ensure that national priorities for the NHS are implemented locally, thus creating tensions in their relationships with FTs. Another SHA Chief Executive explained the position as follows:

There is a strong and genuine belief that Foundation Trusts should run their own business. I don’t think David [Nicholson] is minded to go back on the deal. But at the same time, much of the machinery of the department and of government generally says, actually, we believe in evolution, but at the same time we’d like to keep it in control...particularly when the going gets tough,... Now, clearly it’s part of the job of the SHA, and my other SHA colleagues will say this differently from their own standpoint, to handle whatever pressure comes out of the NHS management board, of which we’re a part, whatever issues, in such a way that it lands locally in a good way. [SHA Chief Executive]

The SHAs seem to be still in the process of finding an appropriate role given the shifts that have occurred around them. They are no longer the major account-holders in the NHS. An SHA chair argued:

We're in transition, kind of halfway, I suspect, to where we'll probably end up, which is a set of meetings between the SHA and the various trusts, which are largely strategy and problem based, and where we're looking for the collective intellect of the people round the table to help us try and solve what are mutual problems. I think it’s inevitable in the current settlement that...Foundation Trusts will operationally want to keep as much independence from the rest of the NHS as they can, to run their own businesses.

There is here a clear recognition that greater independence of the provider side of the NHS by the creation of Foundation Trusts challenges the role of SHAs and call for a renegotiation of the accountabilities which no longer exist formally between Foundation Trusts and SHAs.

We found the pattern of relations between FTs and their SHAs to be varied. Some were very close and the chief executives were content to relate to their SHAs as part of the wider health economy. Others were fiercely independent. One made reference to the model set by Michael O’Leary of Ryanair and the way he pursued an aggressive business model which was neither customer friendly nor partnership friendly and yet profitable – this it was claimed could in some cases be analogous to the approach of some FTs who would demand their dues from their PCTs irrespective of any financial trouble they may have been facing “if they do not pay up for the people that they've asked us to treat, then they’re going to go to the wall, we’re going to go to the nth degree. I don’t care, arbitration, legal action, whatever”.

The alternative, partnership, view was expressed by one FT chairman. He linked it to transformational thinking rather than the restrictions of ‘transactional’ thinking:

This is where we are totally contrary to conventional thinking. The conventional thinking is that all you’ve got to do is to separate
commissioner and provider. Have a properly legally based contract and then you can hold people to account. That is transactional change thinking. But that inhibits transformational change.

During times of trouble such as investigations for breaches etc good relations with SHA can be of some help. In one of the FTs we researched there was an investigation in progress. The CEO of the FT met with the SHA as a result of request from the PCT concerning a contractual issue. In effect, the SHA was brought in by the commissioner. This suggested a fine line between this and the old performance managing role, the FT Chief Executive was determined that he would not allow that aspect to be resurrected. Hence, he says he ‘warned’ them that this must not occur, but when they did start to compare performance etc he claims he ended the meeting and ‘threw them out’.

The role of Monitor and the regulators

Monitor is responsible for licensing new Foundation Trusts, for monitoring their performance and for intervening in the management of the Foundation Trust (imposing changes to the composition of the trust board and requiring that they comply with an imposed action plan) when there is significantly breaching the terms of its authorisation. FTs have to submit an annual plan detailing the major risks to compliance with the Authorisation and how it intends to address these. Monitor, through the authorisation process, may require an NHS Foundation Trust to disclose information including those information requirements specified by the Secretary of State to the regulator. It may also require other NHS bodies to disclose information which the regulator requires for the purposes of its functions (Part I 19.2).

Foundation Trusts’ relationship with Monitor appears to vary depending on local performance. This is reflected in these quotes from different FT Chief Executives:

“Monitor are concerned about the financial well-being of the Foundation Trusts, they spent a tremendous amount of time with us because of our financial problems. So they’ve watched what we’ve done in excruciating detail”. (Chief Exec of an FT in deficit)

In our case the extent of accountability to Monitor feels very light, I suspect that is because we’ve been doing well financially. I suspect if we’d been doing badly financially, there’d have been a very heavy engagement. So, they send relatively junior people liaising with some of my teams, you know…it is mainly data collection and assurance (FT Chief Exec, Midlands)

Because our performance isn’t as good as it might be, we’ve been summoned to Monitor to explain ourselves. Now, I suspect, if we can’t satisfy Monitor, they will change their monitoring machine. At the moment it’s quite an arms-length type of accountability involving quarterly monitoring but that may now change in the light of some performance problems. (FT Chief Exec in breach of waiting times)
Those with problems (at least financial ones) are the subject of much scrutiny while those who are better performing or identify and address problems before Monitor are involved, do not feel the same strength of accountability.

One of the FT Chairs who is very much a champion of Governors revealed the tensions that are felt between the business imperative and the demands that Monitor places on FTs to have ‘sound financial systems’ on the one hand, while on the other maintaining a line of accountability perceived as potentially ‘cuddly and local’ to the members and governors.

‘Well, they tried to bring together two strands which don’t fit. I mean one is sort of high performing organisations which have strong financial systems And the other one was the cuddly, local, accountable, be nice to everybody, be friends with your locality, have an elective process for this that and the other. And, you know, these things are not natural bedfellows and making them work together is actually quite difficult.’

There was some confusion expressed about the respective roles of different regulators, in particular Monitor and the CQC (formerly Healthcare Commission).

“I mean basically as a Foundation Trust, Monitor is by far the main line of accountability and Monitor are only interested basically in one thing - whether we’re in financial balance”.

The question for us is where does Monitor sit vis-à-vis anything else such as Department of Health? And what is its scope? I think they are a little bit in competition with the Healthcare Commission even though they nominally regulate different things.

The coverage of the recent failings at Mid-Staffordshire Foundation Trust gave prominence to the gaps in the accountability structures for quality of care. Our interviewees suggest that while FTs currently feel accountable to Monitor for financial performance and in meeting the ‘must do’ government priorities, they are less clear about to whom they are accountable for quality of care.

**Horizontal Accountability: The relationship with PCTs**

Although the relationship between FTs and PCTs formally could be characterised as of a legal nature based on contracts, in practice commissioners are expected to ensure not only compliance with the contract but more broadly the delivery of standards of care for their local population.

In general Foundation Trusts we spoke to were sceptical about the ability of PCTs to hold them to account.

‘At the moment PCTs are ill-equipped to hold anyone to account, they are almost completely fixated by the need to balance their budgets and they’re doing that in an extremely crude way. In some parts of the country, PCTs are just saying to local trusts, “we haven’t got any money
The strength of the relationship seems to be partly determined by the size of the provider and its relative dependence on a dominant commissioner. Where the relationship is largely co-dependent or there is a strategy of partnership working, there is more contact between provider and commissioner chief executives and perhaps a greater sense of ‘accountability’ albeit an informal one. Relationships with peripheral PCTs who account for smaller volumes of care appear to be more market-like and there did not appear to be a sense of accountability as understood here.

It also appears that when a PCT has a concern it may escalate to the SHA for intervention. PCTs have also become the conduit through which SHAs try and continue to hold Foundation Trusts to account (see above). Two FT Chief Executives gave examples where they had been subject to intervention by the SHA but had done so under the auspices of the commissioners:

we are accountable to Monitor and then also the PCT because the PCT will get monitored by the Health Authority. So, I’ve also had a couple of conversations with the Health Authority about waiting list breaches. Even though we are an FT they’ve come at us through the PCT.

...in relation to a recent service problem the SHA wanted an independent investigation. Some members of my board said they had got no right to ask for it and I would agree. However, they are responsible, if you like, for the patients via the PCTs, therefore, if the hospital, is not delivering because there’s been mismanagement, I can understand why the SHA want to be reassured that their clients or patients whatever you call them these days – customers, are given a fair deal, and also their PCTs have been given a fair deal. (Chief Exec of FT)

**Accountability to the local population**

FTs are also horizontally accountable to their members and the general public, that is why board meetings are supposed normally to be held in public. In practice many trusts have chosen to hold meetings in private claiming commercial sensitivity.

Our board meets in private but we discharge our public accountability through our meetings with governance, and so the Council of Governance meetings are in public. There are certain statutory requirements including consulting on the service and we believe that we’re discharging our public accountability in that way, and the governors are, I’d say relaxed, about that approach at the moment. There was an initial debate about how can we decide to meet in private, and I basically said, well, you’ve got PCTs, if we were to meet in public with some of the negotiations with PCTs about contracts, it would weaken our position, basically.

Of the full panel of FTs where we conducted interviews, approximately one third had their board meetings in public for at least the major part of the
time (usually holding ‘Part 2 meetings’ in private in order to exclude press and public. The Healthcare Commission report on the Mid Staffordshire FT noted that the trust was secretive and that its board met in private. And an HSJ poll in April 2009 found that that less than 25% met in public. This practice contravenes government guidance.

This kind of arrangement by some FTs is not approved of by the NHS at the centre. Commenting on public versus private meetings the NHS Chief Executive David Nicholson has observed:

“We are only at the beginning of understanding what local accountability is. Some trusts have grasped this better than others... I would hope that, over time, people would learn the lesson that transparency and openness is far more likely to secure benefits for their patients. If you look at some of the examples of where we have had problems, openness would have prevented that, so I would encourage them to be more open.” (David Nicholson, HSJ 2 April 2009)

We asked about the views of other board members:

The medics are very happy. There was one non-exec in particular who was uncomfortable with moving away from public accountability, and there was another non-exec who felt absolutely that we should meet in private and he pushed very hard, and he came from a finance background, we didn’t take a vote on it but it was very clear that the majority of the directors wanted to meet in private.

Not only does this board meet entirely in private but its minutes are also not made available.

Psychologically, we’re becoming more and more business-like. It feels different. One of the first things we’ve done is appointed a new director who handles the marketing agenda, so we have a marketing strategy we put it in just a few months ago. That perspective has affected our thinking hugely.

One of the main governance devices to encourage and facilitate engagement between FTs and the local population are the Local Involvement Networks (LINks). These were established in 2006 in every local authority. They are made up of user groups, local voluntary and community sector organisations and interested individuals. The role of LINks is to gather information about local needs and the experiences of users by monitoring local services. Primary care trusts, NHS trusts and NHS Foundation Trusts are legally obliged to allow LINks representatives to enter and view their services, and to provide LINks with information on their publicly funded services. They are able to make recommendations and suggest ideas for improving services to commissioners, providers and regulators. Though these are non-binding, NHS organisations are required to respond to LINk recommendations and be clear what actions they will take as a result (DH 2009 Statement of Accountability).

NHS trusts are also accountable to the wider public in terms of their obligations to provide information under the Freedom of Information Act.
2000. The NHS Confederation issued a briefing at its June 2009 conference urging trusts to become more transparent in light of the steep increase in requests under the FOI. The Confederation said that the number of requests for data has increased by up to 400 per cent in the past year. The Confederation has urged trusts to place more information on their websites. Executive directors in the trusts we researched variously argued that they were committed to as much transparency as possible while others advanced the argument that as they were in effect competing for business in a commercial environment that they had to take steps to protect themselves both from the leakage of commercially sensitive information and from bad news stories that they feared the local press would sensationalise.

Finally, Foundation Trusts are also accountable to their Local Authority Oversight and Scrutiny Committees (OSC). These are special committees in local authorities which examine local plans and scrutinise the way services are run. Although they have no formal sanctioning powers they are able to refer matters to higher authorities. OSCs work closely with local NHS organisations and can summon local health service officials, including board members and staff of Foundation Trusts, to appear before them. However OSCs are encouraged to focus on the work of commissioners of health and social care (DH 2006) and to take a broader focus on health issues (Coleman, 2006) thus limiting the frequency with which they are likely to call on FTs.

Few of the people we interviewed spoke about these relationships in the context of accountability except in a passing manner. Either we might assume that these bodies were not perceived as important ‘account holders’ or they were not understood to constitute a form of accountability.

Next, to help zero-in on the organisational dynamics involved in FT governance and to reveal rather more how it is experienced in practice we report on a comparison based on just two of our FT case studies.

### 5.1.2 A Case illustration: Two London Teaching Hospital Trusts

These case illustrations examine the way in which clinical executive directors and non-clinical executive directors are interpreting and responding to the new opportunities and challenges presented by new governance arrangements and new quasi-market environments.

There have been few systematic studies of the practical reality involved in the enactment of profit centre and service line management initiatives in acute hospital settings and the ways these are understood and negotiated at executive team level.

We found the clinical and non-clinical directors of these organizations engaged in a process of active sense making which was leading to significant changes to the service and also changes to identity. The clinical directors were revealing a willingness to assume accountability for devolved profit centres in their service lines. The non-clinical directors were
supportive of this idea in broad terms but were cautious about releasing ‘too much’ central control.

The general consensus from previous research on clinicians as managers has been that, in the main, these professionals have been equivocal and rather reluctant managerial practitioners (Dopson 1996). Further, it has been also suggested that they are not even receptive to the idea of devolved autonomy (Hoque 2004).

Our work suggests a more complicated picture. The assortment of changes and the way in which a number of them interlock and are reinforcing mean that the penalties for disengagement from this round of governance reforms are much higher than heretofore. The focus of our attention in this analysis is on the upper echelon.

Our central question for these two cases therefore was:

*What are the most significant of the governance changes viewed from within an FT and how are the actors responding to the new mix of principles and the new rules of the game?*

The way in which the top echelon directors of these trusts are making sense of the array of opportunities and threats is the subject of these cases. Six conceptual categories emerged from the data. These were interpretations about the rationale for change; about the relationship between managerial and clinical priorities; about governance requirements stemming from demands of regulators; desirable principles for organising and managing clinical work; effectiveness of the wider health system organisation; and commitment to organizational success. Using these categories, the overall picture is revealed in the data display shown in Table 20.

### Table 20. Trust A and Trust B Compared

<table>
<thead>
<tr>
<th>Clinicians</th>
<th>Trust A Executive Directors</th>
<th>Trust B Executive Directors</th>
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<tbody>
<tr>
<td></td>
<td>Non clinical Directors</td>
<td>Clinicians Non Clinical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Directors</td>
</tr>
<tr>
<td>i) Views of rationale or need for change</td>
<td>Dissatisfaction with previous unresponsive and stifling administrative regime</td>
<td>Need to eradicate entrenched professional &amp; administrative “arrogance”, replace with humbler focus on patient as customer</td>
</tr>
<tr>
<td>ii) Views of relationship between managerial</td>
<td>Advocacy of and accountability to patients, with</td>
<td>Clinicians will always have different</td>
</tr>
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<th>&amp; clinical priorities</th>
<th>ethic of service; responsibility for resource control seen as extension of professional accountability in the interests of patients; recognition that &quot;managerial&quot; clinicians need to mediate this to others</th>
<th>priorities from managers, and need to have financial managers working alongside them at all levels, to build an integrated understanding of performance and how to control it.</th>
<th>clinical managers as mediators: clinicians will only respond to managers who are clinicians and still practising; and general managers need clinical managers to represent clinical viewpoint to them.</th>
<th>priorities, so clinician engagement is sporadic and needs to be worked at; need for managers to take a lead in shaping a competitive mix of secondary and tertiary services &amp; identifying new income streams</th>
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<tr>
<td>iii) Views of governance requirement of external regulators &amp; inspectors</td>
<td>Trust autonomy can be retained by pre-emptively adopting the targets, measures and approaches favoured by external bodies</td>
<td>Strong recognition of accountability to and power of regulatory bodies, failure according to their standards can lead to termination of appointment.</td>
<td>External bodies have driven necessary internal focus on clinical governance, examining current practice and how to improve it and detect bad practice.</td>
<td>Provide necessary stimulus for building an accountability structure, with prominent non exec role; at the same time have delayed more entrepreneurial focus on increasing income and new business streams.</td>
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<tr>
<td>iv) Views of desirable principles for organising &amp; managing clinical work</td>
<td>Responsible autonomy: clinical divisions expected to be accountable for patient outcomes, care processes, sound finances and use of resources; financial autonomy the</td>
<td>Responsible autonomy: clinical divisions as profit centres with range of managerial specialisms, allowed to reinvest surpluses as long as generating a</td>
<td>Emphasis on competence &amp; teamworking between different care professions at all levels; use of management structure and comprehensive performance measurement</td>
<td>Clinical divisions expected to undertake in-depth process analysis and lean redesign, supported by activity based costing and responsibility for profit and</td>
</tr>
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We examine each of these interpretations and stances in turn – first for the non-clinical directors and next for the directors who were clinicians.

**Non-Clinician Director Sense-Making**

In each case, the non-clinical directors included the Chief Executive, the Chair of the Board, the Finance Director, deputy Chief Executive, Operations Director and similar business functions.

**(i) Rationales for change**

Non clinical executives in both cases spoke as if with one voice about their desire to achieve healthcare delivery more attuned to the needs of patients, seen as customers. As the Chief Executive of Trust B put it:

"The best of the service industry has moved on to being accessible, convenient, user-friendly, and has transferred the costs to itself, and

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<tr>
<th>v) Views of effectiveness of wider health system organisation</th>
<th>Concerns that national system of standard prices for procedures does not recognise complexity of tertiary work; or specific demands on the Trust associated with geographical location</th>
<th>Concerns at: lack of integration between strategic plans of secondary and tertiary care organisations; contradictions between expectations of “high performance” and “community accountability”.</th>
<th>Concerns at lack of coherence; external targets on cost reduction contradict measures needed to reduce hospital acquired infection; weight of demands of overlapping regulators; fragmented clinical governance</th>
<th>Concerns that national standard pricing for tertiary work not geared to techniques with lowest mortality;</th>
</tr>
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<tbody>
<tr>
<td>vi) Commitment to organisational success of Trust</td>
<td>High, and reinforced by experience of taking on senior management responsibility</td>
<td>High, reinforced by social commitment to local community and economy.</td>
<td>High, identification with maintaining multi-faceted reputation of the Trust</td>
<td>High, bound up with identification with local community and economy.</td>
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</table>
away from the punter. Whereas, in healthcare, the costs – the travel, right down to trying to park on this site, waiting and so on – are still very much with the patient, and their relatives and carers.”

This aspiration was generally couched in contrast to what the strategic managers saw as the less desirable traditions of the NHS, a high handed, “take it or leave it” attitude as to what services should be delivered and how. The Chairman of Trust A saw his organization as developing along these lines not simply for social reasons, but above all for business reasons, importing a private sector stance that business viability is directly linked to customer service:

“...we are and we need to be much more responsive, much less arrogant, much more externally focused on people rather than on institutions... also much more focus on customers - our last patient survey shows us as being only mediocre in far too many areas .. it’s actually about being an organization that’s fit to do its job...or the business is going to go elsewhere...”

This expresses rather well the external, critical and independent view which a Chair can bring into the heart of an organisation – perhaps especially needed, as here, when the institution is a large, prestigious, teaching hospital.

Executives in each case were also driven by the need to avoid past serious failings that had come to light under previous managerial regimes. So, there was a strong rationale for more transparency and external scrutiny in the way the organization was run and governed.

(ii) Understandings of the relationship between clinical and managerial priorities

A common theme in both trusts was that the perspectives of strategic management were different from those of the majority of clinicians in the central emphasis given to financial viability. This could be brought together with the contrasting perspective of prioritising clinical care and outcomes, but the fit would always be full of tensions and require considerable work in negotiation. One of the Organization A executives, who had come most recently from a private sector organisation outside of healthcare, drew parallels with his current perception of senior clinicians and his previous battles with a powerful sales function:

“...in the same way as someone who’s essentially a very, very good salesperson, may not always make the most sensible financial decision, someone who is ultimately a really dedicated clinician is never going to care quite enough about the finances to make that decision, so it’s actually to do with what level of financial support you can delegate out there as well....so if you can mature finance enough to say, okay, I’ve got a great clinician out there, I trust what he does because I know I’ve got a fantastic accountant riding side-saddle with him...”
His counterpart in Case B showed a similar sense of realism combined with a stance that this kind of negotiation and accommodation is all part of running a business:

“*We fret about it a lot: we worry about clinical engagement all the time….But you shouldn’t judge the fact that we worry about it, that we’re not pretty good at it in many respects.*”

Respondents differentiated their priorities as strategic managers from those of their senior clinical colleagues in one further and significant sense. They emphasised their own role in identifying how the clinical and scientific capabilities of the organisation could be harnessed to bring in new streams of income:

“..*diversifying our income and that’s really about growing fund raising, and it’s also about developing [the Trust’s] commercial services and R&D income…Pathology runs like a business – we’re selling to district general hospitals, primary care, independent sector treatment centres..*”

The implication is that non clinical managers are freer to think about new ways of using established professional expertise.

(iii) Views on external regulators

Executives in both organizations recognized the central need to satisfy the key regulatory agencies in what they were doing, particularly in the context where both organizations were attempting to show that they were well into recovery after encountering serious problems in the recent past. As the Chief Executive of Organization A put it:

*Monitor can sack any of us, the Healthcare Commission can shut bits down if we breach certain standards. So they have different accountabilities but they’re both critical to us*”

In the words of his Chairman:

*“If we don’t deliver the recovery plan I get fired”*

Executives in Case A felt that they had anticipated the kind of solutions to issues that the key agencies, most notably Monitor, would expect them to follow, and had been able to craft versions, for example, of clinical profit centres that served them well. The Chief Executive of Organization B felt that the very specific templates for organizational governance set out by Monitor had been exactly what his organization needed.

In both cases, there was however some resentment that the over prescriptive requirements of regulators had consumed unnecessary management energy. In particular, the Chair of Organization B felt that the demands of the main agencies for over-detailed conformance to governance requirements had held him and his organization back from entrepreneurial activity, engaging with the possibilities of generating new income streams.

(iv) Preferred principles for managing clinical work

Executives in both Organizations saw the future for the organization and management of clinical work in terms of “Clinical Divisions” or “Care
Groups”, each with their own management structure, including a finance function. This can be characterized as a devolved view of organizational functioning and accountability, but distinct from established notions of professional autonomy in that devolved subunits are held accountable for financial as well as all aspects of clinical performance, and also expected to engage in their own strategic planning.

In both Organizations, steps were at an advanced stage for each clinical division to act as a profit centre, producing an annual plan for income and expenditure, and then being held accountable for achieving an agreed surplus. In the words of an Organization A executive:

“the profit centre approach is there to enable that to happen so that, what I’m trying to get to is a position whereby people are incentivized, first, to be profitable, that is, to do work that generates a surplus, generates a margin of profit, and secondarily, to increase activity, particularly that activity which generates a profit, and to be aware of the activity they’re doing that’s making a loss and to either address that to make it profitable, or to stop doing it.”

Divisions were to be allowed to retain their surpluses for reinvestment.

Organization B executives preferred a slightly different flavour in an otherwise similar recipe. They emphasized the possibilities of using formal approaches to process analysis and redesign within all aspects of caring for and dealing with patients, and the need for new management accounting systems, involved activity-based costing, for understanding costs of existing practices, as a basis for making decisions on their viability and directions for improving them. This was intended to provide the basis for strategic planning within each division, as to which care procedures should be expanded, and which not.

The Director of Finance in case A said:

“If they’re delivering then their management will be much freer and if they’re not delivering their management will be much more intense. So I think we’re moving towards a differential management model and there’ll be a much clearer transparency of managers that are delivering and managers that aren’t...Those people whose results are falling into metric two or one then they’ll be the subject to the fierce heat of recovery planning, reporting, delivery, daily reporting...”

(v) Views on the wider healthcare system

Executives in both organizations were critical of many aspects of the complex framework within which they had to operate. They welcomed the new entrepreneurial possibilities by the Foundation Trust concept but they were bemused at the apparent lack of strategic co-ordination of the various agencies in their region. As the Chairman of Organization A said:

“Foundation Trusts have no connection to anything....you’ve got these big beasts wandering around the place...the idea that they are controlled by commissioning is a bit farfetched ... I mean if control is one issue the other issue is how do you make sure that the things they’re developing
for the future are actually what the commissioners want? We’re talking about developing a big cancer centre, a huge capital investment. Now there’s actually no chance of getting our commissioners to sign up to it, the risk is entirely ours. There isn’t the mechanism for making sure that what we want to do is consistent with what the service around wants and there’s no mechanism for making sure that someone else isn’t doing the same thing two miles down the road”

Further, executives in both organizations shared concerns that national standard prices for medical or surgical procedures did not reflect the true costs of specialist tertiary units.

(vi) Commitment to organizational success

It was not a matter of surprise that non-clinical executives professed great commitment to the success of their organizations. This is what senior managers are paid to deliver. However, it worth noting the degree of social commitment that respondents showed when they talked about why their organization and its future were important. Several executives in each organization referred to the importance of their organization to the local area as an employer and as a service.

We can now compare and contrast these responses with those of the executive directors who were clinicians.

Clinical Executive Directors Sense-Making

Clinical executive directors were a new breed of medical director and nurse directors. In these large teaching hospitals covering multiple sites and with multiple constituent elements these top clinicians tended to hold full-time appointments for their directorial duties. As will be seen, they tended not to see themselves as mere ‘representatives’ of the doctors’ voice.

(i) Rationales for change

A first stance we encountered on the part of clinician directors in Organization A expresses dissatisfaction with earlier modes of governance and management within the NHS, seeing them as bureaucratic, unresponsive, and even stifling of clinical priorities and judgment.

According to the Director of Nursing:

“It seems to be, in principle, like a very good idea to get people much more engaged because I think people have lost the will to live under the hierarchical and bureaucratic financial regimes that we’ve been struggling with and they bitterly resented the massive top slice, which has gone into...well, the Finance Director’s back pocket, I mean I’m sure he’s got a good place for it.”

In Organization B the analogous view was that the organization could not continue with what appeared to be an inadequate system of financial planning and control. A more rigorous regime of management control and external scrutiny was seen as necessary. In both organizations, clinician directors were able to explain why new, more integrated approaches to management and governance were needed. There was no illusion that it
was possible to perpetuate or return to a previous golden age when clinicians were just clinicians and managers were unimportant administrators. The old system they argued had failed and needed to be replaced with something else.

(ii) Understandings of the relationship between clinical and managerial priorities

Medical and nursing executive directors in both cases each indicated that they had been on an eventful personal journey to discover how to make sense of their role and identity as clinician directors, and how it related to their earlier calling as medical practitioners. One kind of resolution was expressed by an Organization A Medical Director, who saw his managerial role as still concerned with dealing with patients:

"I have a lot of engagement with care, be it in neurology, obstetrics, cancer... a lot of human engagement with patients, but not as their doctor. So, if you said 'what sort of core values do I have?', the only answer would be those of a patient focused clinician, and I don't suppose that's going to change."

According to this way of thinking, there was considerable continuity between the basic concerns of clinicians and clinical directors, that of the primacy of the interests of the patient and their right to the best available treatment. So management was in a sense an alternative way of fulfilling a professional calling.

One of the Organization B medical directors took a different direction for understanding his own role and the relationship between clinical and managerial perspectives. He felt his new role gave him even greater credibility in representing the clinical perspective at board meetings. He illustrated this by explaining how he had opposed managerial initiatives to reduce the floor area and bed numbers available to a department that had made improvements to its treatment times and so could logistically manage with fewer beds and less floor space. His reason had been that putting more patients in the same beds would inevitably increase the incidence of hospital-acquired infections - a priority not fully understood by the managerial "owner" of the bed reduction initiative.

This kind of recognition that there are important differences between managerial and clinical frames for thinking led several other clinician directors in both Organizations to see themselves in a mediating role:

"You could say in some ways it's still a bridge function between career managers and clinicians and I can sit now very comfortably in the middle and hold hands with them on either side; very comfortably, and it wouldn't be possible to go back."

(iii) Views on external regulators

Like their non-clinician colleagues our clinical respondents talked as though they had internalized a model of responsible autonomy represented to them by external regulatory agencies. They understood that the way for the Organization as a whole to achieve autonomy was to take on the mixture of
clinical and financial measures required by their regulators. And they saw
devolved clinical units below them as needing to make similar sense of how
to behave. According to one of the Medical Directors in Trust A:

“Well, it’s the Monitor for the trust, it’s the clinical board for the divisions.
If a division is so far out of kilter that I, in the clinical board, have not
got a solution then it is possible the executive board will want to look
more closely at that division, but if that division is doing well, executive
board won’t be interested at all.”

There was little indication that any of these clinical executives saw this kind
of external scrutiny as in principle an infringement of professional autonomy
and restrictive of effective clinical decision-making. Rather, the weight of
opinion was that external promptings were appropriate to make sure that
clinicians within an organization operated with due regard for costs of care,
up-to-date evidence as to effective care procedures, and were also open to
regular scrutiny to detect poor practice and understand any deterioration in
clinical outcomes.

(iv) Preferred principles for managing clinical work

Medical and nursing directors in both trusts expressed thoroughly positive
views concerning the devolved models being implemented for the
management of clinical sub-units. They saw the integration of clinical and
financial decision-making at operating level as desirable. In Organization B,
there was a more matter-of-fact acceptance that clinical decisions had to be
brought together with consideration of costs, and that this could be done
through the application of lean process thinking. The director of nursing
was clear that the consideration of finance did not mean that financial
considerations always took precedence. Indeed, she was keen to cite a
case where after thorough discussion and investigation of costs in multi-
disciplinary forum, the division concern had received backing from the
Organization to cross subsidise, temporarily at least, an apparently
uneconomic procedure.

“Now, clipping is quite inexpensive but has a fairly high mortality rate;
coiling is very expensive but has a much better patient outcome. The
trouble is that we don’t get enough money for coiling, we lose money by
doing it. So, as a committee, we looked at that with the clinicians
involved, and we felt that we couldn’t make the decision to go back to
clipping because of the poor outcomes. So we would acknowledge that
we were losing money and seek to make savings elsewhere, but we
would also lobby nationally in order to get the cost of coiling recognised,
so that the tariff would be adjusted, which it was the subsequent year”

In Trust A, medical and nursing directors shared a more thoroughly
entrepreneurial view of the role of clinicians in managing care. This way of
thinking builds links between, on the one hand, apparently traditional ethics
of service to patients and notions of professional autonomy and
accountability in decision-making, and, on the other hand, new
opportunities for embracing financial accountability and benefiting from
financial success within devolved clinical directorates or divisions. The following quotes comes from a Clinical Director in Trust A:

"... doctors are very smart people and the people here are smarter than your norm, and the thing about medicine is that it’s always been associated with money and the making of it, so we’ll only be running this for a bit before someone will come up with notions that will make more money, because they’re very entrepreneurial as a staff....”

(v) Views on the wider healthcare system

Clinician directors’ views of the wider healthcare system within which they operated in many respects reflected those of their non clinical executive colleagues. They complained about the system for setting for tariffs for tertiary procedures, and about the lack of a transparent system for planning tertiary capacity. They also showed considerable concern for the funding and support for the primary care system which refers work to them. They were concerned about the need for more systematic thinking about how healthcare is provided beyond the remit of their own organization.

(vi) Commitment to organizational success

Most of the clinical directors interviewed in both these teaching hospital trusts had worked at the organization, or an earlier incarnation of it, for at least ten years - and in some cases for over thirty. They expressed deep identification with the success of the organization, and like their managerial colleagues, were proud of its role in the local community and economy. The medical director of Organization B brought out a further dimension to this pride in his organization, which related it to his sense of professional pride. He explained that he was committed to safeguarding above all the “reputation” of the Organization, and that reputation meant more than merely how it was currently rated by various regulators. He felt that “reputation” for a hospital was multi-faceted, and meant, amongst other things avoiding negative attributions, for example avoiding high profile disasters, such as uncontrolled outbreaks of infection. But above all he was keen that others should focus on the what “reputation” meant for the organization

"... you know, every day I walk into this hospital through the front door. I don’t actually have to walk through the front door. I could easily walk through a side door. But I walk through the front door, and every day I say, ‘This is my hospital. What am I going to do today to make it a better hospital?’ Now the question is, how do you get everybody thinking like that? That is the issue. And if you do that, then you have reputation, because everybody contributes.”

It was evident overall that in both cases the clinical directors had travelled some considerable distance from the profession-first stance. They were identifying very strongly with the mission and success of their organizations. Indeed, they had come to a judgement that they had rather more of a sustained stewardship responsibility for the viability and success of their organization than the chief executives and general managers who were more likely to come and go between organizations.
In the next case example we switch from London to a Foundation Trust in the north of England. This next case is used to reveal some of the tensions in using the FT concept in practice when to do so involved managing relationships with commissioners and other providers. Most especially, the case is used to illustrate uncertainties among board members of an FT as to how far to push the competitive spirit.

5.1.3 The Riverside NHS Foundation Trust Renal Unit Case Study

This is an account of an FT board in action when faced with a significant commercial opportunity. The FT was recognised a one of the leading trusts in the country and it had a reputation for entrepreneurship. We interviewed the board, senior clinicians and the commissioners. The trust which we term Riverside NHS Trust is located in the North of England. This trust found that it had an opportunity to build a new renal unit. This new venture provoked uncertainties and anxieties among the board members and as such is revealing about the concerns and capacity of NHS FT boards when faced with significant risk and change.

The story starts with a push at national level for more renal capacity within the NHS. The Department of Health expected demand for renal services to double in the next few years. The regional joint commissioning body did an overview of the state of, and demand for, Renal Services, and a National Service Framework for renal disease was developed which produced a number of targets in terms of delivery of renal services.

There was only one provider in the wider region and it was clear that an increase in renal services capacity would be required and that the existing provider would not be able on its own to manage the increasing demand.

As one senior manager observed:

*I remember sitting there thinking we’ve got this business case to write and we know nothing about renal...It was at this stage that we realized that we needed somebody with some renal experience...We had started thinking about how we don’t want the model of a matron and general manager.. the Director of Strategy joined in and a new conversation began in earnest.*

This was a key conversation when the people responsible for initiating the planning of the new unit and preparing the business case realized that they were not only required to present a case for a specialist activity of which the hospital had no experience but that they had to make some key decisions about technical matters and about management and organizational issues. They needed clinical experience as part of and to contribute to, the planning process but they also needed: ‘somebody who could offer a manager point of view, who was going to manage it and I think then it dawned on us that we needed a clinical manager rather than a matron and a general manager.’

The decision to tender for the new renal unit became closely associated with the board’s enthusiasm to move towards the business unit model and it was
seen as an opportunity to pilot this new form of governance. But this carried implications and created issues that needed attention, one of which was: how to create the new sort of clinical manager – a senior clinician who is able and prepared to take managerial responsibility?

There was a major element of risk and attitudes towards risk within the board became important and played a major role in the progress of the project. The ambivalent – some said ‘hesitant attitude’ at board level - towards the risks inherent in the project had consequences for the development of the project.

**The Board’s attitude to risk**

The board’s nervousness about the risks inherent in the project nearly undermined the project. Although, in principle, the board was committed to innovation and to being more commercial, when it came to practicalities the board was very nervous indeed. The key point causing nervousness was the uncertainty about the level of demand.

The project team couldn’t understand the basis of the board’s misgivings and anxiety. For them and for many other people within the hospital and among the commissioners, the data were clear and unequivocal ‘...the evidence was overwhelming, completely overwhelming. What we did was spend a lot of time doing the analysis within the business case, looking at the different variables you would expect to see within a business case and the data were just so powerful. I don’t understand why people didn’t see it ... I kept getting more data, and then going away and doing another business case, more data, more validation, more information, more benchmarking.’

From the point of view of the trust board, the issue wasn’t simply that there wasn’t enough data, they weren’t sure how to assess it, or if they could trust it. As the senior finance manager noted:

> Along the way obviously there was quite a lot of financial risk associated with this because when we were developing the business case we were relying a lot on the... information that we got from Parkside which, when it’s something new and you’re not understanding it, you rely on them. And as we were looking at the income streams we were seeing a big gap between the income s and the expenditure.

The board’s preferred solution was to get the Commissioners to underwrite the early stages of the new unit and to agree to fill any gaps in the income: ‘we had to go back to commissioners and we had to negotiate with them that they would underwrite that difference between the income that we were going to get and the expenditure...... and they were really keen for us to go ahead, they agreed to underwrite it for the time of the development, so that they could get this service up and running, and so that we as a trust weren’t at risk.’ Interestingly, the Commissioners did not agree that they had to agree to underwrite the project in this way. They did agree, as allowed under the commissioning procedures, to make up for any loss of income in the early stages as the unit moved to full capacity but ...we wouldn’t sign up to longer periods than that.'
Ultimately, the only way the worry about inadequate demand could be assuaged was not by data on projected numbers but by trying to get the risk under-written by others. This issue – the apparently neurotic anxieties about patient demand on the part of some members of the executive team - is a good example of the sorts of issue raised by the disjuncture between old and new systems of management knowledge. According to the previous knowledge regime, senior hospital managers were responsible for administration, for compliance with the demands of the SHA, PCT and the Department. But, under the new governance and commercial regime, executive directors were responsible for risk. But risk-taking was not something in which the directors had learned to be competent.

The reason behind the nervousness and the ultra-caution was attributed, by some directors to the uncertainties about devolved governance in the reformed NHS. As one said: ‘If we don’t get over that then we’ll constantly be unable to really change stuff. Is there really a will at the very top national level to let the trust boards go? It seems to us that they are constantly pulled down. As a result, chief executives and directors aren’t allowed to take risks... You’re not going to get people in senior leadership positions to take those sorts of risks when they hear about the response of the centre to how things work in practice: “There’s a bad press, something went wrong, sack them”.

It was as if the board wanted to be more business-like and more entrepreneurial but was not entirely sure what this looked like on practice. Hence, the view from the trust board point of view was as follows:

*We went back to the Commissioners to say, hang on, we’re going with our first proposal. We got the Commissioners lined up with this, kind of, guaranteeing an income. We said to Commissioners, we want a document now. We want a Head of Terms that is going to say that you’ll guarantee our income and be like a pre-contract. They were not familiar with those. I think it has to be done, it was something new and it was very business-like. We were a Foundation Trust, we were trying to act more business-like.*

Evident here was a clash of knowledge and assumptions (old versus new) about how the various parties constituting the NHS should behave towards each other.

**The transition to, and implications of, commercial, competitive ways of working by the Trusts Board**

While the board was ostensibly committed to competition and commerciality, it had little experience of these in practice and had difficulty in translating its intentions into well balanced initiatives. Members of the trust were more used to working co-operatively with other parts of the NHS. Introducing competition to these relationships had unforeseen consequences. The CE in particular recognized that there were new challenges in moving into competitive relations. He said:

*I feel a little like some Russians must have felt when Yeltsin announced overnight that we’re going to adopt capitalism tomorrow and that they*
were going to carry on a managed economy. I feel that what the state has given the state has also taken away from us. I’m operating in an economy where I was told I was going to have freedom and I’m expected to function as a business.

Here we can see that the Chief Executive interpreted the new governance architecture as conditional and uncertain.

Some members of the board saw the new competition as counter-productive to patient care, and to relations with other hospitals with whom a co-operative relationship was important. The move to new ways of working with other suppliers and indeed with the Commissioners generated some unforeseen and undesirable consequences.

The Clinical Director of Renal Services at the regional level based in the Parkside hospital trust was involved in the development of the new renal Unit at Riverside and he observed:

I’d never seen anything like this in the health services. This business-focused competitive approach was a strange concept to me. For me the driver was the clinical need, I then came to this development where there was absolutely no flexibility; there was no question of let’s look at it and see; there was no question of we’re pretty confident this is going to fill up quickly because the people in Parkside have told us that they’re snowed under and we know they are. Despite all that... the number of times I’d said in meetings that there was absolutely no worry about this, and quoted national figures and national growth rates and all the rest of it. But that just wasn’t accepted and everything had to be signed and sealed up front, down to the micro level.

Respondents identified a number of unhelpful consequences of the trust’s new, commercial focus and the competitive attitude which accompanied it. One consequence was that a focus on commercial standards and on competitive relationships damaged previous patterns of co-operation which were beneficial to patients, and to relationships between hospitals within the local area.

One example of this was that during the development of the new renal unit the trust started to place restrictions on their new renal consultants undertaking work which was seen to be ‘for Parkside – the new competitor’.

The Riverside renal clinician commented:

I was in this hospital as a consultant nephrologist and there were patients coming to this hospital needing to be seen and I was told that I couldn’t see them! The trust made it abundantly clear that they wouldn’t let us see them until they had seen a service level agreement from Parkside Teaching Hospitals for that activity.

The problems of having two competing business organizations having to agree this proved to be extremely difficult. The new governance arrangements inhibited the offer of a service even though there was clear local demand. There could have been a straightforward transfer of care and there could have been joint clinics. But the trust board would not allow any
of this to happen during the transfer period. As the senior clinicians perceived it:

The board were much more interested in the bottom line and that they don't get on with Parkside than actually thinking about the longer term. We weren't talking about big amounts of money and we were being paid anyway because the income was coming in from the PCTs as part of the start-up money. It was important for us to keep our hands in, it was important for us to get to know the patients and get a feel for what the clinical problems were in the clinics but the board didn't want us to do it.

Some of the clinicians went ahead anyway and worked in a cooperative way with the ‘opposition’ and the months spent doing those clinics on behalf of Parkside were seen by the clinicians as very important.

The Clinical Director of Renal Services at Parkside commented that if the Riverside Trust and Parkside worked together on procurement issues they would be able, by virtue of the increased volumes involved, to reduce the unit costs of materials and technology. But the response from Riverside was negative:

We got the sense that there wasn’t an enthusiasm to do that. From a business perspective that seemed to me to be nonsensical because clearly the potential for getting better deals would be very significant. Maybe this was just part of wanting to be seen as an independent unit, they much preferred to do new tendering processes for example for new dialysis machines rather than tagging along with existing ones that we already had up and running...there was very strong feeling in my mind that they didn’t really want to be involved with us any more.

Ironically, the development of Riverside’s new renal unit – which was regarded internally as a demonstration and indeed justification of the trust’s new ‘aggressive’ commercial/competitive approach, was only possible because of highly cooperative behaviour of neighbouring Parkside. This help was frequently acknowledged, especially by the project team and the lead clinician.

There was a growing unwillingness to co-operate. Competitor relationship began to build. ‘We were doing other work with Parkside, we wanted to be a second Vascular Hub, Parkside was already a Vascular Hub, we could do with a second hub in this region and we were putting our bit together. And that didn’t come to fruition for that very reason, I think because Parkside suddenly realised that with us being the second Vascular Hub, it was going to take a lot of business. And they were coming along with us and then suddenly their attitude changed and it didn’t happen then. Parkside fought against it.’

Once the Unit was running the other big challenge was organisational – to run it as a virtual stand-alone business unit with a clinician as its head responsible for profit and loss. This innovation was seen as a pilot for a new form of organization – an approach which some senior staff hoped, could be a blueprint for the hospital, as a whole.
A consultant who was recruited to take this role of business unit head and clinical director was told: ‘These are the things the organization expects you to do. This is how much income you are expected to achieve, this is the quality standard that we expect you to deliver. Go away and get on with it.’

**Riverside NHS Trust case summary and conclusions**

This case reveals the practical difficulties encountered by a Foundation Trust Board which, in abstract terms, prided itself on its commercial, innovative and entrepreneurial spirit. They had, they claimed, a ‘can-do’ reputation and yet as this example of the new renal services unit reveals, the members of the board were anxious and uncertain in the face of this new business opportunity. In part there was a revealed lack of competence and practice. In part also there was a desire for some of the old certainties when the centre led the way.

A second facet revealed by the case was the rather ham-fisted switch to a non-cooperative, competitive stance. Erstwhile partners were marginalised and opportunities for the trust’s own clinicians to develop and maintain critical skills were lost in the face of a crude attempt not to ‘cooperate with the competition’.

The problems it encountered along the way were revealing. As many respondents suggested, the problems encountered surfaced important features of the board’s dynamics and raised questions about governance within the trust. The key conclusion is that there existed a gap between the claims and aspirations of the board and the capacities and ways of thinking of the board. Not surprisingly, while the board was reasonably quick to identify opportunities and challenges in the changing environment it was less quick to develop and deploy the necessary attributes and attitudes.

**5.1.4 Conclusions from the acute trust case studies**

Findings from the six main acute trust case studies revealed various insights into the board members’ interpretations of the rules of the game – and indeed the nature of that game. Directors of trusts are working within a system or set of systems comprised of multiple principles and multiple drivers. Knowing how to play multiple games simultaneously is a skill in itself.

The various reforms to governance constitute an admix of rules, institutions and ideologies simultaneously involving central direction, local accountability and professional agency. The way in which the actors make sense of and navigate their way through the cross cutting principles and the layered reforms is a critical issue.

The kind of structural changes to governance described here which involve, inter alia, devolution of accountability to semi-autonomous bodies, have been viewed as part of the “hollowing out” of regimes of state governance. This entails public sector actors having to make themselves more entrepreneurial and innovative while also being held accountable for what they do according to specific measures and by demonstrating that they have followed specific practices. One influential interpretation of this process
is to cast these actors as 'self-disciplining subjects' (Miller and Rose 1992; Rose 1990). The basic idea here is that the practices and routines of governance carry with them systems of rationality which shape how people think as well as behave.

Our data provides a rich understanding of the way this kind of process operates at executive level in acute healthcare organizations. Above all, it indicates the importance of active sense making as executives struggle to reconcile new demands on them, new ideologies of what public healthcare should be about, and relate these to their established notions of priorities and values.

We found clinical and non-clinical directors becoming willing participants in taking up their roles and making complex and potentially contradictory governance arrangements understandable and communicable to others. At the same time, both groups were aware of the potential downsides, the inconsistencies and the contradictions in the systems within which they had to operate. Hence, many of them also took up the challenges of seeking to influence the nature of this context at policy level. They were very much active agents, negotiating both their roles and the rules of the game, rather than mere receptacles of new management practices and modes of thinking about the management of healthcare.

This conclusion can be illustrated for both the clinical and non-clinical executives we interviewed. The clinical executives were open to the idea of experimenting with new approaches to governance and management because they had a range of dissatisfactions with the previous modes of strategic control of their organizations. They recognized that a more integrated approach to the financial and clinical governance was needed, in order to ensure that the limited resources available to their organization and the NHS in general could be put to best use. This led them to accept by-and-large the legitimacy of external monitoring of clinical governance within their organizations, and the idea that clinical divisions or directorates should become accountable for financial performance. Some in particular had found ways of incorporating the focus on accountability for costs within their professed core ethic of service to patients. They made sense of their own role in these terms, and then made further sense of their role in mediating this kind of integrated understanding of clinical priorities to colleagues who did not have the time or inclination to understand it as fully themselves. They were aided in doing so by the discourse of professional accountability closely bound up with the notion of clinical governance. We saw how a number of medical directors had begun to see “clinical governance” as encompassing the professional rhetoric of self regulation, of taking collective responsibility for the performance of colleagues. They were further aided in communicating the concept of the “clinical division as profit centre” by the availability of tools and techniques needed to support integrated decision-making. These included process analysis and the application of “lean thinking” to process redesign, and management accounting techniques that allowed the costs of care processes and procedures to be represented and discussed.
This sense-making on the part of clinicians can be seen as counter-pointed by that undertaken by their non-clinical colleagues. Here we found little trace of what might be called “managerialism” - a view of the primacy of financial management and business rationality and the need to achieve the supremacy of this over established clinical or professional privilege. Whether non-clinical managers came from a public sector health service background, or whether they had recently been brought in from private sector industrial corporations, we found a consistent picture that these executives recognized a wide range of accountabilities, both social and financial. Like their clinician colleagues, they identified with the professional standing of their organizations as much as with financial success. They recognized that the implementation of governance structures as prescribed by external regulators could benefit the coherence of the management and direction of their organization.

But they also saw the possibilities of picking and choosing between the prescribed elements and interpreting them in different ways. So, these non clinical executives too played an active role in shaping the response to the new array of governance requirements. In doing so, some of them called on their established practical understandings of the multiplicity of organizational goals, and the need to recognize that even senior figures in a complex organization are not perfectly aligned in what they are seeking to do. Thus, it was that one recent recruit to a trust board from a private sector organization was able to see how he could accommodate the drive and enthusiasm of leading clinicians in much the same was as he had previously related to sales directors. He had recognized and lived with energetic but financially inconsistent salesmen in the private sector and saw a similar challenge with clinicians in his public sector role. This provides an example of how active sense making on the part of a non clinical manager, in terms not particularly implied by the new governance regime, has provided the necessary conditions for reciprocal and matching sense making on the part of senior clinicians.

These findings about board members’ sense-making need to be considered in relation to the wider context. The design of the new ‘Foundation Trusts’ gave them new status as separate ‘businesses’ with devolved accountability for profit and loss, income and expenditure, and ultimately responsible for their own survival. To varying degrees, the two sets of directors (both clinical and non-clinical) have been able to reconcile their patient-focused mission with a market-oriented stance. They have sought to be entrepreneurial and to create and seize opportunities for ‘new business development’. It was not clear what would happen to a clinical business director whose business failed.

Devolved accountability to service line level reveals tensions. Under pressure from the regulator, trust boards have been encouraged and even required to ensure transparency and income and expenditure, profit and loss for each service line. At minimum this means service line reporting, but there is also additional pressure to develop this into service line ‘management’ (i.e. active devolved managerial accountability) and even the creation of ‘profit centres’ and business units at clinical directorate level.
The behavioural responses by directors, managers and senior clinicians so far have been complex. Managers have been keen to promote transparency and indeed to devolve accountability, but they have also been circumspect about devolving too much power. The kind of accountability they carry makes them nervous about devolving decision making to lead clinicians.

This bolstering of the clinical directorate concept gives further impetus to the idea of using clinicians to manage other clinicians. In the past, however, such attempts have sometimes been seen as subverted by senior clinicians who took on such roles in order to ‘protect’ rather than change traditional practices. It was even suggested that under earlier versions clinical directors appropriated the language of ‘service quality’ in order to defend the status quo and to negotiate more resources (Whittington, McNulty et al. 1994). Whether this is a ploy which could be repeated under today’s more complex and inter-locking governance regime is an interesting question.

The meta-narrative of the policy reforms in the past few years has been of a shift from a centralist, producer-led service to a devolved patient-focused service. To enable such a change, shifts in governance were seen as necessary. Accountability, choice, challenge through multiple providers, regulatory compliance became the key watchwords and enabling devices. Some of these elements have been talked about, and to a degree launched as policy initiatives, before. In previous instances the changes have generally been judged as of limited success. But, as we have indicated, there are some signs that things may be different this time around.

There are a number of indications of such difference. The scale of the change and the multi-layered nature provides a set of mutually-reinforcing drivers. There is considerable professional expertise within the system. The regulatory bodies have recruited staff with high levels of talent and they produced tools which are persuading many management teams to adopt them. A national ‘Appointments Commission’ has taken steps to ensure that persons appointed to senior positions in trusts are of high calibre and are people who broadly share the values of the change programme. Some medical directors, in the larger trusts, had taken on full-time roles as director-managers and had relinquished their clinical practice, others were working have time as divisional clinical directors.

Of course despite the number who were committed to the role and who had the calibre to fulfil the role there were others within the organizations at the next tier down whose attitudes more closely reflected those found in previous studies – ambivalent, essentially committed to the clinical role, reluctant to manage other clinicians and so on (e.g. (Dopson 1996; Ferlie, Pettigrew et al. 1996; Hoque 2004) (Pollitt, Harrison et al. 1991)). However, this time around, there are a number of key differences. One is that those trusts which are leading the change are taking steps to remove these less committed consultants from clinical director roles and they are only able to do this because they have located enough consultants who can and are willing to undertake the role in the fuller sense. It is true that there is no surfeit of these candidates, but it is significant that there are
beginning to be at least enough. Much hinges on how much influence they are truly allowed.

While many lead clinicians at lower tiers than those reported here remain sceptical about the extent of devolved autonomy, there were overall fewer signs of ambivalence about the desire to achieve it. This contrasts with previous studies which placed emphasis on the strong identification with their profession (Pollitt, Harrison et al. 1991);(Hoque 2004). There were, of course, still examples of the latter, but they were less in evidence in the lead trusts which had pushed ahead with the service line management concept. In these latter instances, the allure of spending a proportion of retained surpluses, and the exemplar of divisions and directorates which had invested in new ventures, brought-in new clinical teams and initiated new services, were powerful magnets.

Moreover, some of the leading clinicians who were championing the drive to clinical directorate autonomy were in advance of their chief executives and operations director colleagues and were prepared to play the long game – they were aware that consultants were in post for decades whereas they had seen chief executives come and go. Moreover, unlike previous studies, these lead clinicians were not in thrall to their professions and Royal Colleges. In other words, while few in number this new breed of medical director were marking out new and uncharted territory.

5.2 Findings from the Postal Survey of Acute Trusts

As with PCTs, questionnaires\textsuperscript{10} were posted to all acute trust board members. This included chairs, chief executives and non-executives as well as executive directors. The sample frame for acutes was generated using NHS service directory information and individual websites. In terms of responses, 579 individual returns were received from the sample of 2,051 individuals, representing an overall response rate of 28.2\% - for this type of survey this represents an acceptable response rate. From these returns two datasets were produced, one with individual level data and a second with organisational level data and a cognate set of governmentally sourced performance indicators.

The discussion follows an equivalent two-section structure as was used for the PCT survey report. The first section explores perceptions using individual level responses. The second section moves to an organisational level analysis - the first part of which looks specifically at board practice and performance in terms of HCC Annual Health Check measures; the second part adopts a multivariate approach, using a series of composite governance measures and a broader set of performance measures.

\textsuperscript{10} These questionnaires are reproduced in the Technical Appendix; although they share a core set of questions there are number of differences between the PCT and Acute Trust questionnaires.
5.2.1 Aspects of Governance

This section explores differences (and similarities) in perceptions of groups of members of the board. Here we seek to find whether board directors occupying different roles might tend to report governance arrangements differently. Whether perceptions are affected by the specific characteristics of a particular organisation (e.g. large/small, high/low rated, specialist/non-specialist) is held in abeyance. A fairly obvious categorisation is that between executives and non-executives, i.e. those who operate in a day-to-day interaction with the operations of the Trust compared with those who interact on a more time-limited and discontinuous basis. However, given the structure of the executive group with a mixture of medical and non-medical remits, the report adopts a threefold typology of membership, i.e. executive (non-Clinical), executive (Clinical) and non-executives.

This first part of the report covers three aspects of governance, namely:

i.) perceptions of the regulatory environment

ii.) orientation towards key external regulators

i. Perceptions of the Regulatory Environment

Actions are constrained and enabled by the prevailing regulatory environment. Where this context is clear and precise the nature of such constraints are similarly lucid. Table 21 shows that, although NHS reforms are typically presented as internally coherent and mutually supporting, perceptions vary of this asserted logic. Whilst 39.7% of respondents perceived both clarity and coherence, an even higher proportion (43.2%) perceived the exact opposite. Looking at the extreme ends of the responses reveals that a higher proportion of the sample exhibited strong disagreement (7.2%) than strong agreement (3%).

Table 21. Board members perceptions of clarity and coherence in NHS reforms

<table>
<thead>
<tr>
<th></th>
<th>Clear and coherent logic to reforms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>Exec (Non-Clinical)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>54</td>
</tr>
<tr>
<td>4.40%</td>
<td>29.70%</td>
</tr>
<tr>
<td>Exec (Clinical)</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>46</td>
</tr>
<tr>
<td>12.60%</td>
<td>38.70%</td>
</tr>
</tbody>
</table>
Concerning how different groups respond to this question, there was a statistically significant difference between the role on the board and the perception of coherence (or otherwise). Most noteworthy in this regard is the tendency of the non-clinical executive directors (i.e. the chief executive, finance directors and other senior managers) to perceive coherence within the reforms than did the either the clinical executives or the non-executive directors. Markedly, the clinical executive cadre perceived less coherence than any other group - with 51.3% denying the purported coherence in the recent reforms of the NHS. It could well be that the clinical executives might have a more limited and clinical orientation to their responses, although at the board level participants are expected to participate fully in the discussion of all reforms. The Non-Execs were also sceptical about the degree of coherence and logic to NHS governance reforms.

Reforms are only effective to the extent that they change patterns of behaviour within the Trust. Implementation is crucial to the delivery of policy, in this context over three-quarters (76.8%) of the respondents confirmed the existence of ‘significant changes in behaviour’ effected by recent reforms. This is an important finding as in other instances it is sometimes claimed that policy changes make very little impact on the ground.

Although reforms are acknowledged as significant drivers of a Trust’s priorities, this is by no means a simple or un-mediated process. The practice of governance requires an active sense-making process. Three-quarters of respondents said that one of their crucial tasks as board members was to use its governance powers to determine local priorities and to sift out and de-prioritise some of the centrally-driven reforms. This assessment of the external policy environment alerts us to the importance of the practice of boards as sense-makers. It also hints at an emerging role of boards as front line regulators in their own right.

**ii. Orientation towards key external regulators**

Acute Trusts are surrounded by a plethora of external organisations each of which variously monitors, rates, influences, obliges, the practice of Trusts in general, and the parameters / goals of boards in particular. This section explores the reactions of board members towards three key external bodies (Monitor, the HCC and the DH) and provides an overall assessment of the overall coherence of the messages received.

*a. Monitor / SHA*

<table>
<thead>
<tr>
<th>Non-Exec</th>
<th>18</th>
<th>105</th>
<th>49</th>
<th>84</th>
<th>13</th>
<th>269</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.70%</td>
<td>39.00%</td>
<td>18.20%</td>
<td>31.20%</td>
<td>4.80%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>205</td>
<td>98</td>
<td>209</td>
<td>17</td>
<td>570</td>
</tr>
<tr>
<td></td>
<td>7.20%</td>
<td>36.00%</td>
<td>17.20%</td>
<td>36.70%</td>
<td>3.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

$X^2(8, 570)=24.79, p=.002$
When Trusts gain Foundation Trust status they gain a greater level of autonomy and become subject to regulation by Monitor and free themselves from the close oversight by the SHA. We asked questions of the directors to understand their perceptions of the influence of these bodies on trust governance. NHS trusts were asked to respond concerning their SHA, whilst NHS Foundation Trusts were asked that same question with reference to Monitor.

Looking at the orientation towards the SHA, approximately half (49.5%) of respondents suggested an alignment of priorities with the SHA, whilst 29.3% reported a misalignment (Table 22). For Foundation Trust directors the orientation towards Monitor shows a statistically significant difference with two-thirds (66.5%) perceiving an alignment between the Trust and Monitor’s priorities; with 19.5% perceiving a misalignment. In terms of alignment therefore, Monitor is perceived in somewhat more positive terms than the SHA. This appears to be a positive endorsement for Monitor.

Table 22. Board members perceptions of consonance of their trusts priorities compared with with Monitor (or SHA)

<table>
<thead>
<tr>
<th>Priorities - same as Monitor (FT) SHA (non-FT)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Foundation Trust</td>
<td>2</td>
<td>37</td>
<td>28</td>
<td>115</td>
<td>18</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>1.00%</td>
<td>18.50%</td>
<td>14.00%</td>
<td></td>
<td>57.50%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>%</td>
<td>100.00</td>
</tr>
<tr>
<td>NHS Trust</td>
<td>9</td>
<td>95</td>
<td>75</td>
<td>157</td>
<td>20</td>
<td>356</td>
</tr>
<tr>
<td></td>
<td>2.50%</td>
<td>26.70%</td>
<td>21.10%</td>
<td></td>
<td>44.10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>%</td>
<td>100.00</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>132</td>
<td>103</td>
<td>272</td>
<td>38</td>
<td>556</td>
</tr>
<tr>
<td></td>
<td>2.00%</td>
<td>23.70%</td>
<td>18.50%</td>
<td></td>
<td>48.90%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>%</td>
<td>100.00</td>
</tr>
</tbody>
</table>

$X^2(8, 556)=15.42, \ p=.004$

If we look more closely at the data concerning SHAs, it is noticeable that the clinical executive population report a higher incidence of the perception of misalignment than other groups. In terms of alignment, the non-clinical executives show a higher perception of alignment than the other groups; these differences are close to statistical significance. From this result we could hypothesise that if clinicians were left to run the hospitals they would be more likely to depart from SHA-led priorities than would the Non-Execs. Thus, perhaps ironically it is the ‘external’ independent agents who most closely replicate central polices. This pattern is not reproduced in the Foundation Trusts with respect to Monitor.

b. Healthcare Commission

The Healthcare Commission (now CQC) is, perhaps the most public of regulators. In its production of ratings and, by implication, league tables,
this organisation offers the users of healthcare a public comparative assessment of the quality of Acute Trusts. Overall, 63.2% of respondents identified an alignment between the Trust's and the Healthcare Commission's priorities. Whether this is due to the importance of the Healthcare Commission in the purview of the Trust or a genuine coincidence of priorities is open to question. Some 14.2% report a misalignment (Table 23). In terms of contrasts, the clinical executives report lower level of alignment than non-clinical executive and non-execs (who are in general alignment of perceptions); none of these differences are statistically significant.

| Table 23. Board members perceptions of consonance of their trusts priorities compared with HCC |
| Priorities - same as Healthcare Commission |
| Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree | Total |
| Exec (Non-Clinical) | 1 | 22 | 40 | 104 | 14 | 181 |
| | 0.60% | 12.20% | 22.10% | 57.50% | 7.70% | 100.00% |
| Exec (Clinical) | 4 | 21 | 27 | 61 | 6 | 119 |
| | 3.40% | 17.60% | 22.70% | 51.30% | 5.00% | 100.00% |
| Non-Exec | 1 | 32 | 62 | 155 | 21 | 271 |
| | 0.40% | 11.80% | 22.90% | 57.20% | 7.70% | 100.00% |
| Total | 6 | 75 | 129 | 320 | 41 | 571 |
| | 1.10% | 13.10% | 22.60% | 56.00% | 7.20% | 100.00% |

\(X^2(8, 571)=11.61, p=.169\)

c. **Department of Health**

The Department of Health produces the key policy steer for the Acute Trust sector, however as an organisation it is at one step removed from organisations such as SHAs, Monitor and the Healthcare Commission – indeed the decisions flowing from the Department of Health often affect the operation of these organisations as well as Acute Trusts directly. Of the regulators considered in this section, the Department of Health reports the lowest level of alignment. Under half of respondents (40.3%) described an alignment between the DoH and Acute Trusts; however only a quarter (26.5%) can attest to a noticeable misalignment (Table 24).

In terms of contrasts, the Non-Execs report a significantly lower incidence of alignment (36%) than the other two groups, with the modal response of a neutral character. It seems therefore that in the context of an overall negative perception of the alignment with the DH, non-executives are even
more vociferous than other groups. It seems then, that this group might have a propensity to provide a critical view at the board level.

Table 24. Board members perceptions of consonance of their trusts priorities compared with DH

<table>
<thead>
<tr>
<th>Priorities - same as Dept of Health</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exec (Non-Clinical)</td>
<td>1</td>
<td>51</td>
<td>48</td>
<td>77</td>
<td>4</td>
<td>181</td>
</tr>
<tr>
<td></td>
<td>0.60%</td>
<td>28.20%</td>
<td>26.50%</td>
<td>42.50%</td>
<td>2.20%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Exec (Clinical)</td>
<td>4</td>
<td>32</td>
<td>31</td>
<td>49</td>
<td>3</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td>3.40%</td>
<td>26.90%</td>
<td>26.10%</td>
<td>41.20%</td>
<td>2.50%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Non-Exec</td>
<td>7</td>
<td>56</td>
<td>110</td>
<td>89</td>
<td>8</td>
<td>270</td>
</tr>
<tr>
<td></td>
<td>2.60%</td>
<td>20.70%</td>
<td>40.70%</td>
<td>33.00%</td>
<td>3.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>139</td>
<td>189</td>
<td>215</td>
<td>15</td>
<td>570</td>
</tr>
<tr>
<td></td>
<td>2.10%</td>
<td>24.40%</td>
<td>33.20%</td>
<td>37.70%</td>
<td>2.60%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

\[X^2(8, 570)=18.37, p=.019\]

*d. Mixed Messages*

In overall terms, there is some broad approval of the organisations developed to regulate and oversee standards and policy implementation. It becomes of interest, despite concerns about the alignment between individual organisations and Acute Trusts, to explore the perception of the complementarity of the priorities of these organisations. The analysis has so far unearthed concerns over the coherence of reforms and the need to prioritise certain reforms over others. This somewhat noisy situation could be further exacerbated by mixed messages from different regulatory authorities. In this respect, an emphatic 70.8% of respondents perceived some level of mixed messages with 17.6% of respondents a high level of incoherence in the messages presented by external regulators (Table 25). A mere 14.3% perceived some level of coherence, with less than 1% reporting substantial coherence. If coherence cannot be assumed then the process of developing a strategy for the Acute Trust is rendered problematic in that tensions are apparent within the substantial and intricate regulatory environment. Therefore, a key role for board governance is to make sense of these competing priorities.
Table 25. Perceptions of mixed messages

<table>
<thead>
<tr>
<th></th>
<th>Priorities – mixed messages</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
<td>Neither</td>
<td>Agree</td>
<td>Total</td>
</tr>
<tr>
<td>Exec (Non-Clinical)</td>
<td>34</td>
<td>24</td>
<td>125</td>
<td>183</td>
</tr>
<tr>
<td></td>
<td>18.6%</td>
<td>13.1%</td>
<td>68.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Exec (Clinical)</td>
<td>16</td>
<td>11</td>
<td>92</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td>13.4%</td>
<td>9.2%</td>
<td>77.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Non-Exec</td>
<td>32</td>
<td>50</td>
<td>189</td>
<td>271</td>
</tr>
<tr>
<td></td>
<td>11.8%</td>
<td>18.5%</td>
<td>69.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>85</td>
<td>406</td>
<td>573</td>
</tr>
<tr>
<td></td>
<td>14.3%</td>
<td>14.8%</td>
<td>70.9%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

\(X^2(4, 573)=9.754, p=.045\).

In terms of contrasts, clinical executives are most emphatic in their critical assessment, with over three-quarters (77.3%) perceiving a landscape marked by tensions. By contrast the other executives are less critical although this is a matter of degree only and even the majority of these chief execs, finance directors and others also discern mixed messages.

The contrasts are statistically significant. This finding is of importance for NHS governance. It suggests a disturbing perception among key agents of governance – trust board directors – that the priorities of the governance agencies above them are at odds. The idea of ‘integrated governance’ as a key idea at Trust level thus becomes problematical when it cannot be assumed even at the macro level.

Summary

A noteworthy proportion of trust board members reported that they had difficulty in discerning underlying coherence to the NHS governance reforms. The reforms were, however, for good or ill, perceived to have changed behaviours quite significantly. In such a context, the role of the board acquires centrality: the board members become active sense-makers whose governance work is, at least in part, to interpret multiple and divergent messages, priorities and opportunities.

At the board level this sense-making process occurs in the context of differential participation of key groups. The majority of respondents
reported a strong influence of non-execs and clinicians, strong steers from the chief executive and an alignment in their respective priorities. However, there is not total agreement on these issues with a noteworthy number of respondents reporting a lack of significant influence of key groups (most notably clinicians).

5.2.2 Governance and performance at the organisational level

Having discussed aspects of governance at the individual level, we move to explore relationships between governance and performance at the organisational level. We present first a descriptive analysis of aspects of board practice related to measures of performance before moving to an analysis of the relationship between governance and other performance indicators using composite indicators.

Board practice and HCC performance

We begin with a descriptive single variable approach. This focuses on key aspects of corporate governance relating them to the performance measures used by the Healthcare Commission for Quality of Services (QoS) and for Use of Resources (UoR). The HCC data from the 2007 assessment are used. The second section broadens the analysis in terms of measures of governance and performance.

i. Practice of the Chief Executive

At one extreme a Chief Executive could seek to control the board by adopting an autocratic approach and interacting with the board in only a symbolic manner. Conversely, the Chief Executive could defer to the board in the majority of matters, ceding authority to the board. Our data show a variety of Chief Executive practices. The majority of boards report ‘moderate’ to ‘high’ levels of Chief Executive control of the board, with a skewing towards the ‘high’ category. In general therefore, boards tend to defer to the Chief Executive in most Acute Trusts.

Use of Resources (UoR)

We found some indication of a positive association between balanced board influence and the highest scores on the UoR measure. Conversely, autocratic chief executives were associated with low scores on use of resources. Only 20% of those boards reporting an autocratic chief executive have the highest score on this rating. About half the Trusts reporting autocratic control report the lowest score on this measure (Table 26).
### Table 26. Chief Executive Control and effective use of resources

<table>
<thead>
<tr>
<th>Chief Executive practice</th>
<th>Use of Resources (UoR)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Low control (1.50 - 2.49)</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
<tr>
<td>Moderate control (2.50 - 3.49)</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
<tr>
<td>High control (3.50 - 4.49)</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
<tr>
<td>Very High control – Autocratic (4.50+)</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>Row %</td>
</tr>
</tbody>
</table>

**Quality of Services (QoS)**

On the QoS measure, once again those reporting an autocratic chief executive have the highest percentage of the distribution in the lowest category. But, it also has the highest percentage in the top category (Table 27). There is thus no clear linear relationship between chief executive dominance of a board and the HCC quality of services measure.
Table 27. Chief Executive control and quality of services

<table>
<thead>
<tr>
<th>Chief Executive practice</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low control (1.50 - 2.49)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Row %</td>
<td>0.00%</td>
<td>60.00%</td>
<td>20.00%</td>
<td>20.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Moderate control (2.50 - 3.49)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>3</td>
<td>15</td>
<td>20</td>
<td>5</td>
<td>43</td>
</tr>
<tr>
<td>Row %</td>
<td>7.00%</td>
<td>34.90%</td>
<td>46.50%</td>
<td>11.60%</td>
<td>100.00%</td>
</tr>
<tr>
<td>High control (3.50 - 4.49)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>7</td>
<td>36</td>
<td>32</td>
<td>15</td>
<td>90</td>
</tr>
<tr>
<td>Row %</td>
<td>7.80%</td>
<td>40.00%</td>
<td>35.60%</td>
<td>16.70%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Very High control – Autocratic (4.50+)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Row %</td>
<td>13.30%</td>
<td>26.70%</td>
<td>26.70%</td>
<td>33.30%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Total Count</td>
<td>12</td>
<td>58</td>
<td>57</td>
<td>26</td>
<td>153</td>
</tr>
<tr>
<td>Row %</td>
<td>7.80%</td>
<td>37.90%</td>
<td>37.30%</td>
<td>17.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

**ii. Influence of Non-Executives**

Low or only moderate levels of non-executive influence are associated with the lowest scores on the Use of Resources. Conversely, the higher the level of Non-Exec influence the higher the incidence of the best score (‘4’) for UoR. These figures are confirmed by looking at the mean score in each category, with the two highest influence of Non-Execs, ‘high’ and ‘very high’, showing a mean score that is approximately one point higher that those in the lower two categories (‘low’ and ‘moderate’ influence). The highest level of Non-Exec influence is also reflected in a more extreme effect on UoR (Table 28). These results suggest an endorsement for the role of NEDs.

Table 28. NED influence and effective use of resources

<table>
<thead>
<tr>
<th>Non-Exec influence</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low influence (1.50 - 2.49)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Row %</td>
<td>55.6%</td>
<td>11.1%</td>
<td>11.1%</td>
<td>22.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>16</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>32</td>
</tr>
</tbody>
</table>
On the Quality of Services measure there is however no apparent pattern. We might speculate that NEDs have, so far, focused their attention on use of resource issues rather than quality of service issues. There is, we suggest, now a major opportunity to engage NEDs more effectively in quality and safety issues.

**iii. Influence of Clinicians**

One might expect influential behaviour by clinicians to show some relationship with the quality of services measure to a degree not found with the NEDs or chief executives whose influence seemed to impact most on UoR.

*Use of Resources (UoR)*

In fact, there is some indication that clinical influence is associated with effective use of resources. 60% of those boards with the lowest clinician influence have the lowest score on the UoR figure. 43.9% of those with a ‘very high’ clinical influence produce the highest figure on this Healthcare Commission ratings (Table 29). Whilst these figures might not at first be expected, arguably the association for UoR might reflect positive alignment of management and clinicians and thus underscore the importance of clinical engagement.

### Table 29. Clinician influence and effective use of resources

<table>
<thead>
<tr>
<th>Clinician Influence</th>
<th>Use of Resources (UoR)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low influence (1.50 - 2.49)</td>
<td>Count</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Row %</td>
<td>60.0%</td>
<td>10.0%</td>
<td>0.0%</td>
<td>30.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Moderate</td>
<td>Count</td>
<td>23</td>
<td>11</td>
<td>8</td>
<td>13</td>
<td>55</td>
</tr>
</tbody>
</table>
**Quality of Services (QoS)**

At the extremes of the extent of clinical influence, over 95% of those reporting ‘very-high’ levels of clinical influence score in the top two bands. This contrasts with 50% with those in the ‘low’ influence category (Table 30). The middle distribution (‘moderate’ and ‘high’) exhibits a similar pattern with a more ‘moderate’ influence showing a distribution slightly skewed to a lower level of performance and ‘high’ influence slightly higher. A potential interaction with UoR measure is somewhat clearer than that of this clinically oriented measure. This may reflect an overall smaller influence of trust boards on clinical performance rather than a lack of a specific influence of clinicians on board practice. We also suspect it reflects the variable nature of doctor and nurse engagement in board matters – sometimes they seem to act as if their prime concern is to defend clinical independence.

<table>
<thead>
<tr>
<th>Clinician Influence</th>
<th>Quality of Services (QoS)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low influence</td>
<td></td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>(1.50 - 2.49)</td>
<td></td>
<td>Count 1</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Row %</td>
<td></td>
<td>10.00%</td>
<td>40.00%</td>
<td>20.00%</td>
<td>30.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Moderate influence</td>
<td></td>
<td>4</td>
<td>26</td>
<td>20</td>
<td>5</td>
<td>55</td>
</tr>
<tr>
<td>(2.50 - 3.49)</td>
<td></td>
<td>Count 4</td>
<td>26</td>
<td>20</td>
<td>5</td>
<td>55</td>
</tr>
<tr>
<td>Row %</td>
<td></td>
<td>7.30%</td>
<td>47.30%</td>
<td>36.40%</td>
<td>9.10%</td>
<td>100.00%</td>
</tr>
<tr>
<td>High</td>
<td></td>
<td>7</td>
<td>27</td>
<td>32</td>
<td>15</td>
<td>81</td>
</tr>
<tr>
<td>Count</td>
<td></td>
<td>7</td>
<td>27</td>
<td>32</td>
<td>15</td>
<td>81</td>
</tr>
<tr>
<td>Row %</td>
<td></td>
<td>7.30%</td>
<td>47.30%</td>
<td>36.40%</td>
<td>9.10%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
In general, boards where the chief executive is not perceived as dominating proceedings tend to be associated with higher trust scores using the HCC measures. For non-executives, an impact is most noticeable with regard to higher performance on effective Use of Resources as measured by the HCC. Their influence on the Quality of Services measure is hard to detect. Concerning clinician influence on the board, there is some limited evidence of an impact on the quality of services scores.

Although this descriptive univariate approach offers some hints of potential relations between variables, it is a relatively blunt instrument with which to tease out links between governance and performance. Hence the following section deploys a multivariate approach.

5.2.3 Governance and wider organisational performance indicators using multivariate analysis

We now examine a wider variety of indicators of both governance and performance. As with the PCT data, the Acute Trust organisational level data contains a number of aggregated and composite measures of aspects of governance.\(^1\) In order both to examine the inter-relationships amongst these variables and to prepare for subsequent analysis we entered the twelve variables into a Principal Components Analysis (PCA).\(^2\) The five retained components are summarised below:

- C1: Positive attitude towards the usefulness and relevance of the Annual Health Check
- C2: Alignment of Executives, Non-Executives and Clinicians / Clinical emphasis
- C3: Chief Executive runs the show
- C4: Finance emphasis
- C5: Organisational turbulence

\(^1\) A full description of these variables is given in the Technical Appendix.

\(^2\) A full description of the analysis and components is given in the Technical Appendix.
These components (and the underlying variables) can be contextualised by many descriptive characteristics of the Trusts such as type, size etc. Perhaps the most important here is the status of a Trust i.e. whether a NHS Trust or NHS Foundation Trust. Table 31 compares the respective means of the components for the two types. It can be seen that there is no significant difference in the means of components 1 to 4 whereas there is a highly significant difference in component 5. Given that the components are standardised, there is a difference between Foundation and non-Foundation Trusts of almost one standard deviation, with non-Foundation Trusts reporting the higher values. To give some perspective, in terms of the events comprising the turbulence variable, Foundation Trusts report a mean of 1.7 events in the five year period with non-Foundation Trusts reporting double this, a mean of 3.4.

**Table 31. Comparison of the means of the five principal components according to the type of Trust**

<table>
<thead>
<tr>
<th>Component</th>
<th>Type of Trust</th>
<th>Significance of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Foundation</td>
<td>Non-Foundation</td>
</tr>
<tr>
<td>1</td>
<td>-.073</td>
<td>.039</td>
</tr>
<tr>
<td>2</td>
<td>.060</td>
<td>-.032</td>
</tr>
<tr>
<td>3</td>
<td>-.151</td>
<td>.081</td>
</tr>
<tr>
<td>4</td>
<td>-.131</td>
<td>.070</td>
</tr>
<tr>
<td>5</td>
<td>-.605</td>
<td>.323</td>
</tr>
</tbody>
</table>

In order to examine the relationship, if any, between these five components and measures of performance we use Ordinary Least Squares (OLS) Regression with, in the first instance, the dependent variables being the Annual Health Check results for Use of Resources (UoR) and Quality of Services (QoS). Here the (ordinal) outcomes: Excellent, Good, Fair and Weak are represented by the values: 4, 3, 2 and 1 respectively. Tables 32 (a) – (d) show the summary results when the QoS and UoR ratings for 2008 and 2007 are regressed against the five components (C1 to C5) and the dummy variable (Fndtn). It can be seen that these variables explain about 15% of the variance in QoS and about 55-60% of the variance in UoR.

Looking at the four tables we can discern the following:

---

13 This is an arbitrary, if conventional, ascription; any numeric values preserving the underlying ordinality would serve; experiments with other ascriptions (e.g. 16, 9, 4, 1) provide rather similar substantive results. In any case, as with the PCT case other approaches are either less than suitable or infeasible.
First, the coefficient of Fndtn is always significant (significantly different from zero, Sig. ≤ .05) and positive. In other words, Foundation status is found to be associated with higher performance.

Second, the coefficients of C3 (CE runs the show) and C4 (Finance emphasis) are never significant.

Third, with the exception of QoS 2008, the coefficient of C5 is significant and negative. In other words, a turbulent past is associated with lower trust performance.

Fourth, the coefficient of C1 (positive attitude towards the usefulness and relevance of the Annual Health Check) is never significant except that it is almost significant (Sig ≤ .10) in the case of QoS 2008.

Fifth, the coefficient of C2 (alignment of Executives, Non-Executives and Clinicians / Clinical emphasis) is significant for UoR 2008 and almost significant for UoR 2007.

Table 32. Annual Health Check ratings for 2007 and 2008 regressed against the five principal components (C1 to C5) and dummy variable (Fndtn).

(a) Quality of Services 2008 – R² = .154

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>2.869</td>
<td>.080</td>
<td>36.062</td>
</tr>
<tr>
<td></td>
<td>C1</td>
<td>.106</td>
<td>.062</td>
<td>.130</td>
</tr>
<tr>
<td></td>
<td>C2</td>
<td>.052</td>
<td>.062</td>
<td>.063</td>
</tr>
<tr>
<td></td>
<td>C3</td>
<td>-.053</td>
<td>.062</td>
<td>-.064</td>
</tr>
<tr>
<td></td>
<td>C4</td>
<td>.096</td>
<td>.062</td>
<td>.118</td>
</tr>
<tr>
<td></td>
<td>C5</td>
<td>-.091</td>
<td>.069</td>
<td>-.111</td>
</tr>
<tr>
<td></td>
<td>Fndtn</td>
<td>.485</td>
<td>.146</td>
<td>.283</td>
</tr>
</tbody>
</table>

(b) Use of Resources 2008 – R² = .557

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>2.561</td>
<td>.069</td>
<td>37.072</td>
</tr>
<tr>
<td></td>
<td>C1</td>
<td>-.016</td>
<td>.053</td>
<td>.016</td>
</tr>
<tr>
<td></td>
<td>C2</td>
<td>.110</td>
<td>.053</td>
<td>.112</td>
</tr>
<tr>
<td></td>
<td>C3</td>
<td>-.081</td>
<td>.054</td>
<td>-.083</td>
</tr>
</tbody>
</table>
What is most surprising in the above analyses, certainly in contrast with the PCT case, is the almost invisibility of C1 (Positive attitude toward the Annual Health Check) in relation to the Annual Health Check ratings for both Use of Resources and Quality of Services. At the other extreme there is the (almost) ubiquity of Fndtn and C5 (Organisational turbulence). In the latter case, the kinds of events captured in the variable org_turb are likely to have been triggered by problems in a Trust, therefore the negative association between C5 and performance would not seem surprising. Similarly, the positive association between Foundation Trust status and performance does not seem surprising.
It is apparent that ordinal variables with rather few categories such as UoR and QoS are not very discriminating. There is a likely to be a substantial ‘middle ground’ of Trusts which are not very different from each other and this lack of variability makes it difficult to detect rather weak effects which, nevertheless, might exist. In order to investigate this, we carry out an analysis excluding this ‘middle ground’. At one extreme, we include Trusts which are Weak in at least one measure and no better than Fair in the other. At the other extreme we include Trusts that are Excellent in at least one measure and no worse than Good in the other. This retains approximately half of the Trusts in the sample and in effect contrasts the lower quartile with the upper quartile. The results of this approach are substantially equivalent to those shown above: the ubiquity of Fndtn and C5; the invisibility of C3 and C4; the sporadic appearance of C1 and C2\(^{14}\).

Performance measures such as these Annual Health Check ratings attempt to capture multiple dimension of performance in a single index. In doing so they become somewhat distanced from operational realities. This is especially so of Quality of Services which is assembled from performance against a large number of standards and targets. We therefore extended the above style of analysis to examine individual aspects such as: hospital acquired infections (MRSA and Cdiff); the 18 week waiting list target; patient complaints; mortality rates; reference cost efficiency etc. These results are not reported in detail here because, almost without exception, they yield little in the way of statistically significant and interpretable results.

However, patient and staff satisfaction scores might be seen as important measures of performance in their own right. For a number of years adult hospital inpatients and hospital staff have been surveyed on an annual basis\(^{15}\). The 2007 Inpatient Questionnaire (results published May 2008) contained, amongst seventy or so questions investigating patients’ opinions about various features of their hospital stay, a question:

“Overall, how would you rate the care you received?”

The possible responses (with ascribed scores) are: Excellent (100), Very good (75), Good (50), Fair (25), Poor (0). This allows the computation of a score for patient satisfaction for each Trust by averaging the scored responses of all the individuals in the sample. The distribution of such scores obtained in 2007/08 is shown in Figure 5.

\(^{14}\) The tabular results of this analysis are reproduced in the Technical Appendix

\(^{15}\) The data resulting from these surveys is available for download from the Healthcare Commission’s (now Care Quality Commission) website.
Figure 5. Distribution of ‘Overall Satisfaction’ scores in the 2007 Adult Inpatient Survey.

The results obtained when these scores are regressed against the five components and Fndtn are shown in Table 33(a). Table 33(b) shows the results for a less nuanced dependent variable i.e. the proportion of respondents in the Trust using the rating ‘Excellent’. The results are quite similar to each other and also broadly similar to those obtained previously: the statistically significant variables are C5 and Fndtn.
Table 33. *Patient satisfaction regressed against the five principal components (C1 to C5) and the dummy variable (Fndtn).*

(a) Overall Satisfaction – $R^2 = 0.131$

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>77.003</td>
<td>.469</td>
<td>164.130</td>
</tr>
<tr>
<td>C1</td>
<td>.515</td>
<td>.371</td>
<td>.108</td>
<td>1.389</td>
</tr>
<tr>
<td>C2</td>
<td>.486</td>
<td>.365</td>
<td>.104</td>
<td>1.332</td>
</tr>
<tr>
<td>C3</td>
<td>-.367</td>
<td>.365</td>
<td>-.079</td>
<td>-1.006</td>
</tr>
<tr>
<td>C4</td>
<td>.590</td>
<td>.364</td>
<td>.127</td>
<td>1.623</td>
</tr>
<tr>
<td>C5</td>
<td>-.860</td>
<td>.400</td>
<td>-.188</td>
<td>-2.150</td>
</tr>
<tr>
<td>Fndtn</td>
<td>1.579</td>
<td>.872</td>
<td>.161</td>
<td>1.811</td>
</tr>
</tbody>
</table>

(b) Proportion rating 'Excellent' – $R^2 = 0.111$

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>35.104</td>
<td>.566</td>
<td>62.037</td>
</tr>
<tr>
<td>C1</td>
<td>.581</td>
<td>.447</td>
<td>.103</td>
<td>1.299</td>
</tr>
<tr>
<td>C2</td>
<td>.246</td>
<td>.442</td>
<td>.044</td>
<td>.557</td>
</tr>
<tr>
<td>C3</td>
<td>-.374</td>
<td>.440</td>
<td>-.068</td>
<td>-.851</td>
</tr>
<tr>
<td>C4</td>
<td>.508</td>
<td>.450</td>
<td>.090</td>
<td>1.129</td>
</tr>
<tr>
<td>C5</td>
<td>-.772</td>
<td>.480</td>
<td>-.143</td>
<td>-1.608</td>
</tr>
<tr>
<td>Fndtn</td>
<td>2.352</td>
<td>1.045</td>
<td>.202</td>
<td>2.251</td>
</tr>
</tbody>
</table>

The corresponding comprehensive Staff Survey had questions relating to a previously validated multi-item scale of ‘Job Satisfaction’. Here the values ranged from 1 (very unsatisfied) to 5 (very satisfied). Again averaging over all the individual respondents in a Trust provides a measure of job satisfaction for the Trust. The distribution of these results is shown in Figure 6 and the results when regressed against the five principal components and Fndtn are shown in Table 34(a). Table 34(b) shows the results for a scale item representing the extent of individuals’ positive feelings towards the Trust in terms of: communication, staff involvement, innovation and patient care (distribution shown in Figure 7). Once more, in both cases, we are drawn to the roles of organisational turbulence and Fndtn.
Figure 6. Distribution of Job Satisfaction scores in the 2007 Staff Survey.

Figure 7. Distribution of Positive Feelings scores in 2007 Staff Survey.
Table 34. Job Satisfaction and Positive Feelings regressed against the five principal components (C1 to C5) and the dummy variable (Fndtn).

(a) Job Satisfaction – R² = .144

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant) 3.375</td>
<td>.008</td>
<td>434.306</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>C1 -.003</td>
<td>.006</td>
<td>-.033</td>
<td>-.427</td>
</tr>
<tr>
<td></td>
<td>C2 .008</td>
<td>.006</td>
<td>.105</td>
<td>1.370</td>
</tr>
<tr>
<td></td>
<td>C3 -.006</td>
<td>.006</td>
<td>-.072</td>
<td>-.929</td>
</tr>
<tr>
<td></td>
<td>C4 -.005</td>
<td>.006</td>
<td>-.063</td>
<td>-.818</td>
</tr>
<tr>
<td></td>
<td>C5 -.016</td>
<td>.007</td>
<td>-.202</td>
<td>-2.350</td>
</tr>
<tr>
<td></td>
<td>Fndtn .033</td>
<td>.014</td>
<td>.200</td>
<td>2.309</td>
</tr>
</tbody>
</table>

(b) Positive Feelings – R² = .248

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
</tr>
<tr>
<td>1</td>
<td>(Constant) 2.884</td>
<td>.018</td>
<td>158.364</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>C1 -.009</td>
<td>.014</td>
<td>-.047</td>
<td>-.658</td>
</tr>
<tr>
<td></td>
<td>C2 .022</td>
<td>.014</td>
<td>.114</td>
<td>1.586</td>
</tr>
<tr>
<td></td>
<td>C3 -.018</td>
<td>.014</td>
<td>-.093</td>
<td>-1.280</td>
</tr>
<tr>
<td></td>
<td>C4 .001</td>
<td>.014</td>
<td>.006</td>
<td>.079</td>
</tr>
<tr>
<td></td>
<td>C5 -.050</td>
<td>.015</td>
<td>-.258</td>
<td>-3.212</td>
</tr>
<tr>
<td></td>
<td>Fndtn .117</td>
<td>.033</td>
<td>.287</td>
<td>3.541</td>
</tr>
</tbody>
</table>

Summary
For both overall Annual Health Check ratings and ‘ingredients’ such as patient and job satisfaction links between performance and Trust status and organisational turbulence are suggested. Clearly claims about causality cannot be made but it would seem that both the autonomy of Foundation Trust status and stability are desirable.

The foregoing analysis has used statistical significance at a conventional level of 0.05 (occasionally relaxed to 0.1) to focus on results. An over-emphasis on statistical significance can, however, prevent the reporting of descriptively interesting results which together can produce a compelling insight into potential relationships between governance and performance. If
we relax the requirement for statistical significance in appreciating the results obtained (both reported here and unreported) it is possible to make some more general observations concerning the values of the coefficients in the regressions:

C1 – (Positive attitude towards the usefulness and relevance of the Annual Health Check) almost always positive;

C2 – (Alignment of Executives, Non-Executives and Clinicians / Clinical emphasis) always positive;

C3 – (Chief Executive runs the show) almost always negative;

C4 – (Finance emphasis) positive and negative;

C5 – (Organisational turbulence) always negative;

Fndtn – (Foundation status) always positive.

5.3 Summary of findings about governance of acute trusts

NHS governance reforms were seen as influential on practice. Board priorities were in the main seen as in tune with those of key external bodies. While these findings offer a positive assessment other questions were raised. Board directors reported conflicting messages between the multiple bodies to whom they had to report.

In working their way through this environment, boards, in general, draw on the range of expertise available to them (both Non-Execs and Clinical Execs) in a participative and broadly balanced manner.

The fact that sense-making is deeply ingrained into the practice of boards of Acute Trusts means that a simple mapping of performance onto measure of governance is made more complex by the intervening variable of the particular sense reached within a particular board. Despite this complicating factor, our analysis has highlighted links between governance and performance.

Participation, in particular clinical participation, in the governance process is linked with increased performance. Where a board fails to draw on its resources effectively, and hence the board fails to operate in accordance with the precepts of best practice, i.e. as a forum for sharing expertise, such a situation militates against good performance. Where decisions are reached through an excessively autocratic leadership style, this is similarly problematic. NEDs have made a significant impact on use of resources but their unrealised potential is in improving quality. They are largely recruited for business acumen but, as we have seen, they can have a sound understanding of the role of customer-facing staff.

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16 Again emphasising that no assertions of causality are being made. The data is cross-sectional and quite highly processed.
Turbulent organisations – those subject to incessant external intervention and/or regular changes in board members, were associated with poor performance outcomes. Indeed, if the issue of sense making is important then an unsettled organisation might not be able to develop a sufficiently clear and coherent sense of a direction with which to achieve higher levels of performance. Governance is indeed linked to performance but the linkages, as this section shows, are complex.

Fuller conclusions and implications about governance in acute trusts are explored in more detail in the concluding chapter of this report.
6 Findings about Governance in Mental Health trusts

This section is based on interviews with senior managers, clinicians and board directors (executive and non executive) in two mental health trusts – one in the North of England the other in the Midlands. The interviews and other forms of data collection focused on the following four questions:

1. What is distinctive about mental health service?
2. What are the distinctive governance issues?
3. What governance arrangements were in operation?
4. What relationships with other organisations were affecting governance?

We found that the issues raised were broadly similar in both of these case study trusts. Hence, in order to help allow some of the local context to emerge in the discussion, in the ensuring sections we focus on one of these trusts. The direct quotations therefore are drawn solely from this trust. Material from the second MH trust is used only as comparative background.

6.1 What is distinctiveness about mental health services?

There are currently 60 mental health trusts in England of which 36 were FTs in June 2009. These trusts provide inpatient and outpatient health and social care services for people with mental health problems.

Mental health continues to be the subject of a series of critical reviews and investigations often with remarkably similar findings. Recent reviews of two separate homicides carried out by mental health service users have identified common findings (Hancock 2008; Royston Reviews 2008). These reviews found lack of integrated and co-ordinated services; inadequacies in the provision of services for individuals with a personality disorder; lack of a proactive approach; immaturity in the application of the Care Programme Approach and the Unified Assessment Process, inadequate attention to the assessment, identification and management of risk; poor communication and inadequate systems for the sharing of information across agencies and between organisations. These findings amount to an indictment of governance in these cases.

Mental health trusts have come late to the Foundation Trust process and there is some questioning among practitioners about the appropriateness of the acute trust business model to MHTs.

Mental health has also experienced limited development of information systems, metrics and the apparatus of commissioning. Payment by Results
is also late under development. ‘Commissioning for quality and innovation’ (CQUIN) will apply a year later than in acute care. The CQUIN payment framework has been introduced to encourage NHS organisations to sharpen their focus on quality by making a proportion of their income conditional on locally agreed goals. Under CQUIN trusts can earn (in 2009/10) 0.5 per cent of their contract value by meeting local quality improvement and innovation goals. Trusts will have a CQUIN scheme linking payment to local quality and innovation goals. Providers will lose income if they do not agree to a CQUIN scheme. PCTs, in charge of overseeing the payments, will be able to benchmark provider organisations using CQUIN scores.

On the other hand, mental health can argue that it has a more impressive track record of user and carer involvement and well developed models of engagement with local authorities and voluntary organisations. Until recently, the services were subject to a different regulatory regime but, since April 2009, the Mental Health Commissioner role has come within the remit of the Care Quality Commission in England. PCTs tend to rely on the provider trusts to help shape PCT commissioning priorities. On the other hand, providers argue that PCTs often see mental health as an easy target for tendering exercises to demonstrate contestability.

Respondents tended to argue that mental health is different. A number of arguments were presented: payment is through block contracts rather than payment by results (PbR); there is a tendency to be squeezed by acute providers in the local health economy; Service Line Management (SLM) is especially difficult in this service context because it is especially problematical to link income with activity; there are complex pathways and long term conditions; and there are complex interfaces with Social Services and the Criminal Justice System.

6.2 **What are the distinctive governance issues?**

The above distinctive features of the sector fed-through into distinctive governance challenges.

The chief executives we interviewed observed that there were a number of governance challenges: deaths are more obvious and more headline-grabbing, suicides feel very different when compared to complications arising during operations. Governance feels risky they contended because discharges from treatment need a special set of relationships with Social Services; joint working is more obvious and intimate. An underlying challenge it was suggested is that PCTs lack clarity about mental health and so relationships with commissioners are immature.

Further, it is harder to define success compared with, say, surgery. Long term relationships with service users perhaps need attention to interim goals rather than just outcomes. There is less of a split between community and non community services as they operate in the same organisation (either the trust or the provider unit) although some elements such as substance misuse have been outsourced apparently because they are easier to tender for rather than because of any logic of service delivery or
efficiency. Reconfiguring of services from acute to non acute is a key direction of travel and work in these areas was said to have anticipated Darzi-style ambitions.

The chair of the governance committee in one of the trusts argued that governance was different in a mental health Foundation Trust ‘both procedurally and in texture’. Mental health trusts have the power under the Mental Health Act to detain individuals. The Act makes reference to ‘the hospital managers’ which in mental health refers to the body which is responsible for running the establishment. Nowadays, ‘hospital managers’ refers to the board of the trust. In most cases, the board would set up a special Committee to undertake the trust's duties and responsibilities under the Act which includes powers to discharge people detained under various sections of the Act and therefore appeals to the hospital managers would be made.

Due to an oversight in the establishment of Foundation Trusts, non executive directors found they had the personal responsibility of sitting as designated hospital manager determining whether an individual should continue to be detained. As one NED observed:

‘This would take about an extra day a fortnight but it put me very much in touch with the service’

Although this anomaly was corrected in 2007 and that function can now be delegated, it highlighted a significant governance difference - board members in this sector needing assurance that this role is being performed effectively:

‘Risk is very different in a mental health trust, with regular instances of users harming themselves and others, and very difficult decisions needing to be made on detention versus liberty.’ (NED, MH FT)

A Governance Chair also commented on the role of Commissioners:

‘It is bad news to a have commissioners who don’t know what they are buying. We have found that the intelligent commissioners are the ones who spend more. Some PCTs regard an MH trust with no formal tariff a useful means of carrying forward spare monies. In lean years we were the piggy bank from which to draw, in good years the mattress’

He suggested that although core services such as inpatient, forensic and depression were probably safe, services such as employment support were particularly vulnerable to marketisation.

Additionally, staff have a different approach to their work and patients than, say, surgeons. Relationships are enduring, partly because of length of engagement, but also the ‘mindset of psychiatrists is different.’ Another manager who had recently left a mental health trust to take up a commissioning advisory role observed:

In general, I think it is important to recognise how complex governance is in mental health. It is relatively simple within a third wave NHS acute
FT but, when considered in the round from both viewpoints of commissioning and provision it is terribly complex in mental health

Respondents identified a range of ways in which governance of mental health was different and more challenging. They pointed to the lack of focus and the problems deriving from poor commissioning. They said that national targets were weaker and less clear making governance priorities also less clear. There is little or no outcome monitoring and no nationally agreed outcomes measures so it is difficult to govern from this point of view. There is an absence of a tariff and agreed currencies. There are poor information systems -although these are being developed. There is a general absence of robust service specifications. There is a growing use of third sector providers who operate lean infrastructure. Partnerships are required for a range of services, which blurs the lines of accountability e.g. Children's Trusts, Drug Alcohol Action Team. There is a challenge in sharing information across organisations when coordinating care. The stigma associated with mental health has at times created a challenge in recruiting "the best" NEDs and chairs. PCTs board and acute commissioners do not understand mental health and may see it as someone else's business.

The CEO revealed acute awareness of the heavy responsibilities involved in the very difficult tasks of containing individuals, taking away people's liberty and for others taking the risk to liberate them into the community. He linked these risks strongly to issues of governance:

Those are issues which we must debate and use our (FT) membership to debate with, and specifically our council to debate with, and have conversations about that. My desire is to run an effective organisation which is alert to these concerns. Yes, it's got to be Monitor-compliant, and, yes, it's got to grow, if it's relevant, ethical, and local. But even more it has to do all this while having the debate openly in the public square (CEO)

The new DH contract, of which CQUIN is a component, provides a framework for governance and accountability. The challenge is in the capacity and capability of commissioners to implement it. But it also operates alongside new, raised expectations from commissioners.

Informants argued that 'For too long mental health trusts have been able to operate almost independently of their commissioners and been used to a working environment where they are the key decision maker in relation to service delivery and the future of mental health'.

One of our case study mental health trusts was in the process of applying for Foundation Trust status. We interviewed the Chair, the Chief Executive and a number of their executive and non-executive directors. This Trust has a comprehensive range of services (mental health, learning disabilities, specialist drug/alcohol services, and forensic) across three local authority administrations.

The trust had established a “2014 Vision and Service Model” - a new work programme with an overall aim to modernise care and facilities. The priority objectives were to transform community services so as to provide a clearer
pathway for service users and referrers; and to achieve excellence in inpatient services through an improved focus on the inpatient pathway and the ‘service user experience’.

Four work areas led by clinicians have been established. These are specialist Learning Disability Services; inpatient services; integrated locality services and clinical networks. The CEO argued:

We’ve taken a stance of being a local, ethically based, organisation. Our core mission, our purpose, is around rights, communities, and inclusion, which offers us the chance to play in a slightly wider field than mental health and mental disability alone: we’re very interested in the well-being agenda, for example. And we can say what that means in practice, rather than just articulating it at a high level. What that means for us in practice is that we will have some interesting conversations about integrating care and about the compelling issue of dementia. We are very interested and concerned about the complexity in the youth services area. Our intent is to be more joined-up around emerging problems - risk-taking behaviour, sexual health, drug-taking, emergent mental health problems - creating systems of care and pathways of support around people. So, all of that is in our purview.

The Executive Nurse observed:

things like deprivation of liberty, seclusion, section, those sort of mental health key areas that wouldn’t be pertinent in other trusts and other organisations, are very focused issues for us. We know that we must ensure that we’ve got stronger governance in place. I mean, the longevity of service users and carers in terms of being within our system requires a different approach

The trust board had recently considered the new ‘national challenges’ identified by David Nicholson, NHS Chief Executive, at the 2009 Chairs Conference. They talked about the requirement for boards to ensure that high quality services were embedded and systematic, not just in their own organisations but in the health and social care communities in which they operate. Second, they had noted the impending restriction on funding. Third, the importance of ensuring help to communities to respond to economic and social problems – including for vulnerable service users, ensuring local businesses are supported, as large employers of local people, and as leaders in the community’.

The chairman welcomed these priorities as he said they fitted well with the Trust’s mission. Other board members argued that they were already addressing these issues through their strong partnership model and their engagement with users in job creation but also in anticipating future financial constraints. For example, the Chief Executive maintained:

For us it’s rather more about best benefit for pound spent, and it’s about management of risk, and it’s about mitigation, particularly as we venture into the rather colder climate of post-2011 in terms of negative growth for the NHS and so on. So, the board is concerned with two things. One is getting the most impact for the money we have and our projected
funds across a five-year period; and second is looking at potential sources of mitigation income, flexing our roles, our core jobs, into areas where we might gain to spread the risk a little bit further.

6.3 Governance arrangements and board operation

The trust has a relatively new board with a strong executive team. We found it to be confident in board debate and challenge. The NEDs are relatively new and they appeared less confident in making challenges especially when the Chair was absent. The trust board members were all positive about the move to Foundation Trust status which is creating new opportunities. They had sought considerable support from other trusts in showing them the way.

We would not have translated our vision for that into a partnership with Rethink and with Assurer had we not had a tendering process. Equally, at the other end of the spectrum, we should not be doing some of the work around tertiary services that we're doing. We could do better in partnership - again, with the third sector (Chief Executive)

The trust had a very positive commitment to its Foundation Trust 'Council of Governors'. The trust had recruited 9,000 members into the trust. The Senior Independent Director (SID) is planned to hold a key role in relationships with the Council. Much of the planned developments for the trust reflected an asset rich infrastructure (especially in terms of the size of the estate) but the current business climate with its impact on the ability to sell surplus assets may compromise these plans. The CEO recognised that mental health has operated 'under the radar screen' over the years and that there are significant issues of modernisation to tackle including cost effectiveness, connecting with the community, family life and activism and the need to pay greater attention to growing demands of dementia and youth.

The governance regime has been modernised and the board team have all attended a substantial Board Development Programme provided by the Institute of Directors. The trust has rejected full 'Integrated Governance' for the time being, having established a distinction between operational support issues and clinical issues, however there is recognition that this causes some complexity e.g. in relation to information sharing policy and it may be reviewed. There is no formal process of reviewing board directors’ performance, although there have been many ad hoc reviews. The CEO rather than the Chair reviews executive directors in their board role.

Different respondents held varying reviews about the distinctiveness of governance in mental health trusts. The consensus seems to be that the principles of governance are the same, but the issues and circumstances for mental health trusts are different. This reflected the vulnerability of service users; the complexity and longevity of relationship with service users; that central initiatives are often delayed for mental health but trust can choose to fast track in order to influence in relation to local services e.g. PBR (now...
field testing in this trust) and CQUINs and Foundation Trust status; less weight of evidence available on mental health and less for boards to consider; relatively narrow range of service/specialities compared with acute sector; weak systems and metrics. Other comments were that MH boards can have a sharper focus than acute sector FTs; but that partnerships and commissioning is complex with a wider range of players. MH trusts reported that commissioners are often ‘naïve’ about mental health issues so the trust has to ‘lead’ their PCTs rather than vice versa. Finally, it was claimed that Monitor is less familiar with mental health and that SHAs are weak in providing intelligent information relevant to mental health.

The chairman of the trust and a number of the other directors confirmed the view that governance is not entirely different in MH compared with acute trusts but that systems and mindset do need to be different to reflect the distinctiveness of mental health.

The trust has been through a major overhaul to overcome a number of difficulties including financial problems, relationships between managers and clinicians, and low service user satisfaction. The new management team is working through historical due diligence (HDD) as part of its FT application and seeking to implement a new vision and philosophy of care. Much is in transition but the senior management team is very upbeat about the future, realistic about a number of challenges and was seeking to act as a leader in service development.

The trust argues they have created a streamlined approach but there appears to be a ‘belt and braces’ approach to overcome gaps and lack of confidence.

‘The Audit Committee is meeting every month now for the next year until we get FT; it’s understandable. I find in the NHS people lack self-confidence in a way that surprises me a lot’ (Chair)

‘The culture in the NHS and what I’ve seen is - if doubt, stick a NED on it because you tick the box’ (NED)

‘NEDs still lacking self confidence, tend to let it go to managers/clinicians’ (Executive Director)

The board committee structure was being revised. In addition to the Remuneration Committee and the Audit Committee, there is a Finance and Investments Committee which reflects recent financial turnaround priorities. This committee is chaired by the trust chair. There is also a Performance and Assurance Executive established essentially as an integrated executive team but NED pressure is encouraging this to have some non exec presence and preferably NED Chairmanship. This ‘Committee’ has a series of sub groups reflecting distinct clinical and operational threads. Senior Managers argue this provides appropriate focus for important issues that need development but also admit there can be a problem in deciding which group owns the issue and ensuring issues such as information sharing are fully integrated. This ambivalent status reflects uncertainty about the boundary for governance compared with management.
The Chairman argues that these models are a pragmatic response to serious issues the trust faced two years ago and that governance must evolve - taking into account the managerial, clinical and board resources to hand. ‘This does not mean that will not make further changes when we can but the approach felt right to us at the time.’

Other executives highlighted that there is a perceived weakness in the main delivery arm, the Care Services Directorate, which covers nursing, wards etc and where the governance structures aren’t clear: ‘The reality is decisions aren’t clear, controls aren’t clear, the purpose isn’t clear’ (Deputy CEO).

The Board Assurance Framework is being reconstructed around strategic objectives to engage with communities and users; this was previously a weak point. The board is also considering if this can be further improved by distinguishing between generic assurance and positive evidence based assurance; and by aligning board agendas and Board Assurance Framework identified high risk areas.

There are, nevertheless, outstanding areas of risk:

‘I think we’ve got to be careful around some of the issues to do with vulnerable children. I think we’ve also got to be careful around issues to do with regular users of a core mental health system who need sustained and localised and integrated support’ (CEO)

‘Also with local government partnerships, careful not to create a, sort of, sub-prime market around some of those services - things being managed at a distance - around some of those core services’ (CEO)

Unusually, the trust does not have a senior management team as such; but it does have an executive team that meets once every Monday to both move business forward and where timing fits to receive feedback on board meetings. Again, this raised questions about the boundaries of governance and management. As the key director responsible said:

I’m absolutely clear with all of them, there are no governance decisions taken. Because that’s part of the problem – just where are decisions being taken? There’s no clarity in the system. So, if we want a decision taken on policy, funding, anything; we go through someone in the governance system. (Director of Governance)

With the advent of FT status there will be a Nominations Committee and a board of governors:

‘We’re not setting up loads of committees; we’re just going to stick to a membership development one. We’ve got a raft of things that we want them to look at. Basically going through the Monitor survey, the developing governance, all the sort of lessons learned. We see them getting involved in service development, we see them getting involved in community works; we’re getting community governance as appointed governors. We see those community governors being a real driving force for us and they include a youth governor who is going to be elected.’
We’ve got someone coming from a regeneration community group’
(Executive Nurse)

In terms of board operation/dynamics, respondents suggested that the executives are very effective in the board meeting, although this may be a result of not having rehearsed issues in an SMT:

The board we’ve just had, the executive challenge was really, really strong, the strongest it’s ever been. Constructive, helpful, but perversely the NED challenge was weak (Director of Governance)

This raises a concern as to whether the board, rather than just executive directors is able to shape policy:

I think there’s been quite a change... one of our NEDs is really good about contracting work, she has influenced the way our PCT has put its bid in for Improving Access to Psychological Therapies (IAPT). So she’s influenced and angled and supported in terms of helping to shape what that might look like. I think there’s something about an honest broker, of ensuring that we can provide the assurance, that what we say is really happening. Our NEDs are pretty good at going out there and asking the right questions. (Executive Nurse)

and able to challenge executives:

Some are. We’ve got a very new board, which in one way is good, because those that joined recently, now know what the role of the NED is and are working to their role, rather than to a previous ambiguity. (Executive Director)

Similarly are executives able to take that challenge, not as a personal affront but as appropriate scrutiny?

They’re up to that, yes. We’ve had some very good board development. We did the IOD programme course together as a whole board and that helped enormously (Executive Director)

The board has been subjected to a number of reviews and observations for example by the SHA and has found these challenging in interesting ways. ‘I think the Chair was uncomfortable with that kind of observation, of scrutiny of performance’ (Executive Director)

This raises one of the interesting unresolved dilemmas for FT status boards. Do they hold their meetings in public or private? If in public are they real meetings or a PR exercise?

I’m not saying we’ve made that decision yet, but I think there’s a lot of pressure to do our business in public... It’s very clumsy. And what we’re troubled by in this is to be authentic and honest about this and we really haven’t settled on this - there is business that needs to be done in private... particular issues that would be problematic like how do we formulate a structure for an honest debate around risk? We know that for every ten or eleven thousand people, there may be a homicide. We know that. Now, we’ll do our best to stop that but that’s a very difficult issue to talk about in public (CEO)
The other key issue concerns board development. This board was not doing a formal annual board performance review. But it did have some other ways to review and improve its own performance. One of the main ones was for the chief executive to review and discuss the performance of the executives while the Chair gave direct feedback to each of the NEDs. On top of this, the Director of Governance said:

*I give feedback to the Chair. On the Monday after the board meeting the executives get two lots of feedback. They get how the board went in terms of behaviours and challenges and so on directly from me, although sometimes I just literally count the questions*

### 6.3.1 Relationships internally and with other organisations

Relationships with Commissioners remain ambivalent. There is recognition of the need for and the benefit of more knowledgeable commissioners. Concern was expressed about current commissioner capability:

*I think there is a big issue around commissioning concerning capability and capacity. You know, they simply don't pay enough to get people into the system ... they just simply haven't got them; they can't recruit people to a level they need (Chief Executive)*

*So for example, we've driven the agendas around the quality schedule on the CQUINS for the first year, because they wouldn't have known what to ask us to do (Executive Nurse)*

Commissioners are under pressure to be seen to be leaders in the local health community and needing to market test services. Mental health feels vulnerable to this pressure and as an easy target for contestability:

*We're an easy hit in terms of them demonstrating that they're good commissioners because the plurality of the market dictates that (Executive Director)*

*We are paid in wrong currency (beds) for new approaches (Executive Director)*

*We're trying to do service line management around pathways. But we're still paid by occupied bed days (Executive Director)*

This trust was relying heavily on advice from a successful acute Foundation Trust concerning how best to redesign its governance arrangements ready to apply for FT status:

*We have a close arrangement, they act as an expert friend and they do deliver. They were looking to do some pilot consulting and we were no threat to each other in terms of geography or in terms of type of service offered, and it was, kind of, a marriage made in heaven, and we've stuck together since (CEO)*
The trust also had a partnership with its local university and was working with a national leader on communities, rights and inclusion. As one Director said:

*Now things are clearly changing rapidly. Benchmarking is becoming critical; We’re a pilot for PBR for learning disabilities. So the world is catching up but for governance, that’s meant that what goes to the board has been quite different in many, many, ways (Executive Director)*

### 6.4 Summary

While some of the broad principles of governance are similar in mental health as in acute trusts, nonetheless, there were, as we have shown, some distinctive difference in the governance challenges which MH trusts faced.

Both MH trusts were evolving their business and service models. They had clear and personal visions of the future direction for service delivery in concert with others. In both cases however the governance structures and practice were still relatively immature.

The MH trust boards faced four particular tensions:

1. The dissonance between a community and social care function and a commercial purpose
2. The immaturity of systems (commissioning, metrics) and analysis to support the needs of the service and the boards
3. The role of the board directors in balancing strategic focus and line of sight assurance that systems are safe, effective and value for money without losing sight of purpose or micro managing. In mental health this is magnified with the distinctive role of ‘the hospital manager’ which should draw the attention of non-executives to both their corporate and individual responsibilities
4. The need for effective ‘added value’ partnerships and joint working to overcome the persistent barriers of communications and culture so often highlighted in investigations.

The MH trusts applying for Foundation Trust status have subjected themselves to a rigorous process of review. While most board directors welcomed this a few were concerned that the exercise was potentially diverting them from their core values and core purposes. World Class Commissioning has not yet tested mental health services to any great extent. To date, suggested our interviewees, mental health commissioning has been especially weak. And intriguingly this weakness had not really worked to the advantage of the MH provider trusts, rather it had resulted in some neglect. Overall, however, the two MH case studies suggested that board directors who were progressively inclined were welcoming the challenges which Foundation Trust status allied with revised commissioning were provoking. They were setting about preparing their governance arrangements for the new challenges and they seemed confident that their services would be improved as a consequence.
PART 3: CONCLUSIONS AND IMPLICATIONS

7 Sense making about Governance

In this part, the general conclusions from the study as a whole are presented along with their implications for theory, future research and for practice.

We set out to identify and understand the meanings which key actors within the NHS gave to the concept of governance, what behaviours they constructed in response to these meanings and to discover what patterns of governance were emerging in practice and with what consequences.

Our conclusions, organised under each of our four main research questions, now follow.

7.1 What do national level system designers intend and expect when they make policy choices affecting organisational forms and governance?

The main findings from our interviews at the national level with the designers of the governance arrangements can be summarised as follows. First, there was a shared view that the reforms of NHS governance – the way individual trusts are and should be run and the frameworks under which they work – were absolutely necessary. Second, although the variety of policy makers and voices at national level means that there were a variety of principles constituting the desired alternative approach, there is also a common sense-making core –the idea of devolved corporate governance at trust or organisational level, with trust boards taking responsibility for clinical and financial performance according to explicitly defined performance criteria, the assessment and management of risk, and the development of capability to perform effectively in the future.

Third, in terms of the mechanisms for governing the interaction and coordination of healthcare across different kinds of trusts in locality, a variety of principles were recognised as in tension with each other. Market, hierarchy and networks were all part of the mix. The idea of patient choice suggests that PCTs should commission similar services from a variety of competing providers. ‘Stronger commissioning’ implied greater influence of PCTs over providers and the more active management of highly specified acute service contracts to ensure that best value is achieved. This might be viewed as a version of “relational contracting” where parties trade with another on the basis that they are strongly dependent on each other and so need to bear in mind each others’ long term interests. While many policy makers emphasised the need for more mature and independent minded
Foundation Trusts and PCTs, setting their strategies and marshalling their own resources to deliver them according to customised performance measures, others emphasised the continued importance of centrally-defined targets being enforced, particularly with respect to PCTs through SHAs as a channel of hierarchical control.

At the level of SHA boards there was more uncertainty about governance. On the one hand, SHA chief executives, as members of the overall NHS management board, experienced themselves as powerful conduits of central thinking and requirements, not only from the NHS Management Board but also from the secretary of state and indeed the prime minister. On the other hand, SHA board members experienced themselves as lacking power to influence Foundation Trusts, other than through PCTs as their commissioners. They sometimes saw themselves as bypassed altogether when the DH or NHS put new requirements on PCTs. The issue of the degree of autonomy and agency of SHAs with respect to the DH is unresolved. This is mirrored by the perception of some of our interviewees that the governance of SHAs by corporate boards with their own non-executive directors was not necessary or appropriate.

Finally, it was widely accepted amongst our interviewees that there was uncertainty about how all this would be received and acted upon by key players in the trusts (clinicians and managers alike). The idea that this was something of an ‘experiment’ was not refuted by those we interviewed at the centre. Hence, the main thrust of our research project was designed to explore how these actors at trust level would interpret and respond to this governance reform package and its inherent set of varied incentives.

In addition to the unresolved tensions between competition and collaboration, and between autonomy and hierarchical direction evident in our interviews with policy makers, our findings at trust level (summarised below) highlighted three further tensions identified within the policy literature in Part 1. These concern the extent to which governance focuses on what the board does versus wider processes; the extent to which governance is seen as a formulaic “paper chase” as opposed to a genuine and constructively critical examination of performance; and whether the new governance really does lead to greater public involvement and influence as opposed to greater state control.

### 7.2 How do organisational level managers (chief executives and their teams) interpret and respond to the policy message they receive concerning governance and organization?

A first conclusion concerning how senior members at trust level have interpreted the governance directives impinging on them from above focuses on overall motivations and aspirations in engaging with the NHS governance regime. Across our different case studies and survey respondents in primary care and acute trusts, it is possible to identify a
spectrum of engagement with the idea of corporate governance at trust level (see Table 35):

Table 35. Continuum of Modes of Engagement with Governance Reforms

<table>
<thead>
<tr>
<th>Spectrum of Engagement</th>
<th>Description</th>
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<tbody>
<tr>
<td>Recalcitrance &amp; division</td>
<td>Minimal compliance by some senior figures, usual managers; overt or covert refusal to participate by others, typically clinicians; conflict between these two groups at trust level</td>
</tr>
<tr>
<td>Passive Compliance</td>
<td>Taking on requirements for structures and performance reporting in order to win resources; consensus amongst board that this needs to be done, but diverse requirements are simply absorbed and bargained over rather than critically assessed and prioritised</td>
</tr>
<tr>
<td>Innovative reworking</td>
<td>Enthusiastic seizing of key elements of the governance regime and associated conceptions of performance to craft a trust strategy that addresses clinical and managerial priorities with local meaning; shared commitment to a locally-grounded vision of organizational success</td>
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While our national postal survey results, together with our case studies, suggest that a proportion of acute trusts locate towards the left hand of this spectrum, they also suggest that the distribution of PCTs and acute trusts is centred somewhere right of the central category. Most trusts are in the process of making their own sense of inconsistencies in NHS governance models and requirements. Our case studies revealed PCTs, acute and mental health trusts where senior figures believed very strongly in the value of the corporate strategies, risk assessments and performance measures. Not least they recognised that their boards had to produce to keep external agencies well disposed in order to ensure a future flow of resources. Our acute Foundation Trust boards showed pride in their abilities to develop leading specialisms and services that PCTs wanted to commission, to manage resources effectively and to achieve good or excellent ratings according to clearly visible performance indicators and standards used by regulators. At the same time, they wanted to seize opportunities to offer services on a commercial basis in new markets.

Our PCT boards embraced the concept of commissioning on behalf of the population and the central role of public health needs analysis. They accepted the challenge to develop a PCT corporate strategy to allocate resources in order to improve health inequalities rather than simply improve referral times for those needing acute services. Likewise, they accepted the need to work with providers to improve clinical pathways from a systemic perspective. Such was their commitment to the concept of PCT boards as developing and managing local commissioning strategy, that they also showed very little opposition to the separating-out of PCT community health services into a separate provider arm. Similarly, our mental health trust case studies show boards keen to innovate in pursuing a population well-
being agenda, expanding conceptions of mental health care through working collaboratively with social services.

Above all, in none of our cases did we find any substantial body of opinion that wanted to turn the clock back to some earlier era of the NHS that was less beset by formal governance requirements or central direction, and where doctors were more in (individual) professional control. There was widespread support for the goal of moving towards more integrated managerial and clinical evaluation and shaping of services, and indeed for local autonomy and devolved accountability at trust level in doing so.

Such findings are consistent with an optimistic reading of where most NHS trusts are in terms of two of the polarities described in Part 1 concerning whether governance is purely a matter for the board or something wider, and whether it is a matter of box-ticking and form-filling, as opposed to an opportunity for creative and meaningful performance evaluation. Although some senior staff complained about the amount of time they spent in committee meetings or reviewing risk registers and performance reports, few questioned the value to their organization of producing clear strategies, risk assessments and performance reports. And we found that while for most players within trusts (including executive and non-executive directors and clinical practitioners) the term ‘governance’ was in the main interpreted to mean aspects of the work of boards, there was also recognition that boards operated within a wider and shifting architecture of governance at multiple levels. Above the level of trust boards, the complex lines of accountability and the system of regulation were recognised as relevant. Likewise, the diverse underlying principles of market, hierarchy and collaboration were also accepted as fundamental drivers of modes of governance. And looking below the level of the board into the operating mechanisms of their trusts, directors showed awareness that quality assurance and risk management practices needed to involve front line clinical and support staff as well as their first line supervision.

**A second area** for drawing overall conclusions about trust level sense-making is closely related. It concerns the overall complexity of accountability experienced by trusts and their boards. Directors of trusts are working within a system or set of systems comprised of multiple principles and multiple drivers. Knowing how to play multiple games at once is a skill in itself. The various reforms to governance constitute an admix of rules, institutions and ideologies simultaneously involving central direction, local accountability and professional agency. The way in which the actors make sense of, and navigate their way through, the cross cutting principles and the layered reforms is a critical issue.

There has been a long standing tension between formal accountability upwards and informal accountability downwards in the NHS. Our research suggests that changes to the NHS in recent years including the creation of Foundation Trusts, the reorganisation of PCTs and SHA regions, the growth in local public accountability, and the creation of new independent regulators have created new tensions and confusion in how organisations are governed and how they are held to account. New accountability
relationships have often been grafted on to existing ones, resulting in a sometimes confusingly complex pattern of accountability.

There remain in place the formal hierarchical accountabilities characteristic of a publicly funded health care system which run upwards from the local level through an intermediate tier (SHAs) to the Department of Health and ultimately to Parliament. For primary care trusts and NHS trusts that are not Foundation Trusts this vertical relationship remains. However, for Foundation Trusts these old accountability relationships have formally been removed but, as we have shown, continue to play out in more subtle and informal ways.

Although, formally, SHAs no longer have any direct accountability relationship with FTs, we have seen a tendency to try and continue to hold provider organisations to account diagonally if not vertically and/or to manage their performance through the commissioning process. SHAs primary relationship in the reformed NHS is through the PCTs as commissioners. Yet, they are held to account for the overall performance of the NHS locally including the performance of FTs. Unless SHAs responsibilities change there will continue to be confusion locally about how much an SHA can, or should, be able to intervene or call to account Foundation Trust boards or Chief Executives.

Another aspect of Foundation Trusts accountability is the contractual obligations with PCTs via the commissioning process. This is mentioned by Monitor as one way in which FTs are held to account. To date, they have proved a relatively weak mechanism. But given the weakening vertical lines of accountability to government as more NHS trusts achieve foundation status, the role of commissioning is likely to become more important.

Our findings have illustrated how formal accountability for trust boards runs in several directions - vertically, diagonally and horizontally. These are further complicated by some of the informal accountability relationships which actors in the system experience and which they talked openly about during the interviews. Theoretically, more accountability might lead to more complete and therefore better accountability. Conversely, the multiple lines of accountability might indicate complexity which could breed confusion and may actually weaken accountability as a consequence. There was evidence in the data we collected which warn of this danger. If a board director is unclear whether they are primarily answerable to one or another body, they are likely to expend energy giving accounts of their activities and performance to multiple bodies. If the institution holding others to account is not clear either what they are holding another body to account for, or whether it is their or another body’s responsibility, this may result in gaps or overlaps in accountability arrangements. In addition, the development of partnerships, joint funding and delivery arrangements further complicates finding the locus of accountability and the governance of the sharing of risk.

Despite (or perhaps because of) the plethora of account holders there is some lack of clarity where accountability and governance ultimately resides in the NHS. This is further reflected in the widespread perceptions from our
surveys of PCTs and acute trust directors that the demands of NHS national and regional bodies and of regulators lack coherence.

**A third area** of conclusions about trust level response to NHS governance policies and practices concerns the degree to which trust directors, in the face of these complex and sometimes overlapping demands, experience themselves as able to gain autonomy in how they set strategy and go about shaping its delivery. The question of whether NHS governance arrangements result in trust autonomy as opposed to central constraint was one of the key themes identified from the literature in Part 1. The picture emerging here is that considerable central constraint appears unavoidable, and may be all that is evident, particularly for trusts which take the middle “compliant” position in the continuum of engagement with reforms. However, moving to the right in the direction of “innovative reworking” involves recombining some centrally prescribed governance elements to produce something that is also distinctive and locally relevant.

On the side of constraint, in all of our case studies some directors indicated that centrally-determined targets and priorities figured very prominently for trust directors. Indeed, with good reason, for many directors were able to recount exemplary lessons of trusts where central targets and goals have been ignored or not met, where chief executives and chairs were summoned to receive very clear directions or were dismissed. This is seen most clearly with regard to financial deficits and to national targets such as the 18 week wait from GP referral to treatment and the 4 hour maximum wait in A&E. There were numerous other examples which reflect changing political priorities (infection control instructions, mixed sex wards, etc). NHS staff including directors, managers and clinicians of all types, find themselves in the middle of a whole new array of structures, procedures, standards, and targets. Failure to accord with central wishes can result in the imposition of turnaround teams. The average tenure of a trust chief executive is widely believed to be just 2 years. This perception helps cement what Bevan and Hood (2006) referred to as the ‘targets and terror’ approach.

There is additional evidence that board members are being carefully selected in the first place so that the potential for opposition to the central agenda is minimized. For example, with non-executive directors of PCT boards recruited and selected by the Appointments Commission, there is a pervasive perception among board members that the kinds of people appointed to the newly reconfigured PCTs are of a different kind than had previously occupied these positions. The seeming new ideal is a person with some considerable business and financial experience in the private sector. Apart from the actual staffing of the boards, this pattern of appointments also sends a message about expected priorities.

The PCTs have been recast as the instruments for reshaping healthcare provision through their design and commissioning functions. In the past couple of years as the government has also given massive priority to eliminating budget deficits. These messages have fitted well with the new appointments which shifted the emphasis from erstwhile community
representation and health service experience to an emphasis on commercial and financial management. Indeed, the single-minded focus on finance and the need to make a surplus is indicative of the extent of the retained command and control governance mode. Putting the question of rights and wrongs of the matter to one side, the fact is that trusts which had for years found that deficits were tolerated have had to learn the new rules of the game. Meanings have shifted decisively.

Above all, the multi-tier governance apparatus for PCTs and acute trusts alike presents healthcare staff with a formidable set of institutions which in some ways at least reinforce each other in shaping priorities for what is to be done. Within this the regulators play a crucial role. The regulator for Foundation Trusts, Monitor, is perceived by directors of trusts to wield very considerable influence. Directors seek to anticipate Monitor’s requirements and expectations and try to ensure conformance with them. Likewise, the DH standards for better health which are monitored by the Healthcare Commission are regarded as the priority targets by the primary and acute trusts. To a very large degree, trusts are considered ‘well-governed’ if they managed to meet the standards and targets stipulated by Monitor and the Healthcare Commission. Other, additional objectives seem subsidiary to these.

As regards varieties and types of governance arrangements for achieving these seemingly largely centrally driven objectives, again we found strong pressures in the direction of uniformity. Provider trusts revealed themselves to be increasingly subject to the rules of Foundation Trust status and PCTs similarly subject to the scrutiny of World Class Commissioning, which might suggest that the scope for variation in board level governance structures was limited. Further influences which impelled a certain degree of conformity to a broadly common set of principles included guidance about good governance from bodies such as the Appointments Commission and the DH-sponsored Integrated Governance Handbook, the guidance from some SHAs based on the Combined Code, and the influential role of management consultancy firms as well as peer to peer learning and advice. Yet, despite all these forces, we did find some variation in strategic objectives, in formal governance structures and most especially in the practice of governance.

Variation in strategic objectives occurs within the framework of meeting national targets. We found Foundation Trust boards beginning to identify particular additional services they might be able to market on a commercial basis, on top of the range of provisions prescribed for them. Examples are providing pathology services to other trusts, marketing an activity-based costing system developed in-house to improve cost management at clinical directorate level, and entering into partnership arrangements with hospitals overseas. Such strategic initiatives can be understood as drawing on particular competitive capabilities. For PCTs, locally-grounded initiatives based on the public health profile of the population focussed for instance on reducing teenage pregnancy rather than child obesity, or vice versa, depending on the board’s analysis of local conditions, and discussions with key partners, such as the local authority.
In both kinds of trust, directors often spoke of how the trust could earn autonomy to pursue meaningful locally relevant objectives as long as they “delivered on the national targets.” The possibility of gaining a degree of autonomy seemed a key component in their sense-making of what being a trust meant. However, for all this enthusiasm, locally-derived targets and initiatives to deliver on them were at the time of interviewing generally still at an early stage of formulation. It is therefore difficult to draw conclusions as to how many trusts will successfully achieve the time and resources to pursue these trust-specific strategies in the face of an unrelenting stream of central targets and a coming period of financial stringency in the public sector. A further factor which may steer trusts away from pursuing a larger locally-justified portion of their strategic portfolio is the concern we heard that if a trust starts to use a larger proportion of unique locally relevant indicators and targets, it is more difficult for the DH and SHAs to compare its performance with other trusts. If so, the trust and its board may lose the security of knowing that they stand in the national league table. The irony is of course that, particularly for PCTs, grounding strategy in the specific needs of the local population will inevitably lead to more idiosyncratic indicators and targets.

Variation in governance arrangements for delivering strategies occurred first of all in terms of board structures, covering roles represented on the board and the structure of main committees through which the board conducted its business. Across our acute trust and PCT case studies, there was some basic uniformity in terms of adhering to a unitary corporate board with a membership of 12, with six executive director posts matched by six non-executive posts, including the Chair. However, there was wide variation in terms of which senior management roles were executive directors with voting rights, as opposed to directors who attended board meetings and took part in discussions without formal voting rights. In most cases, there was mutual recognition that the executive team was in effect larger than the number of formal executive directorships, and a feeling that the formal title of Executive Director was somewhat arbitrary and not conducive to true teamworking.

There was wide adherence to the idea that all main board committees should be chaired by non-executive directors (though some trusts objected to this vehemently), and considerable confidence in the capability of the new breed of NEDs to carry this responsibility. However, we found considerable variety in committee structures, and, in all but one case, very limited progress in moving in the direction of the much simplified committee structure advocated in the *Integrated Governance Handbook*. The FTs in particular had, in addition to an audit and some form of remuneration committee, committees that examined strategy, performance, health and safety, and sometimes diversity and equality issues. They also typically had some form of governance committee that oversaw a wide range of clinical and non-clinical risk and quality assurance activities and a committee that oversaw the functioning of the FT governors and member bodies. Overall, board committees appeared to be delving into and evaluating operational processes and performance. This is a rather different picture from that...
espoused in the *Integrated Governance Handbook*, where the board should be hearing reports from executives as to the adequacy of existing assurance processes and what was already in train to rectify perceived gaps, and otherwise focussing on strategic matters. The variations between trusts in the precise nomenclature and remit of board committees appeared to result from a mixture of what had become established and the preferences of chairs and chief executives in post.

We saw signs of moves towards a simpler committee structure in the PCTs we studied in spite of the added complexity of needing to establish what is in effect a separate board of the autonomous provider organisation as a committee of the overall PCT main board. One of the PCTs we studied had managed to combine this development with the dissolution of a distinct governance and performance committees of the main board, with governance improvements and performance reporting handled by the main board.

In all our cases it was apparent that the way that board level governance arrangements functioned was closely linked to how performance management and quality assurance were organised at operational level. Boards or board committees could function more effectively if provided with risk management and performance management data not simply reported upwards from the operational level, but already processed and acted upon by operational management and professionals. This permitted the board or its committee to take a view on where performance or risk management could be improved, rather than becoming involved in decisions in actually managing performance or risk. Under the next heading of the third research question, we discuss in more detail the models of organising healthcare delivery we found in acute trusts and the variety of models for organising commissioning in the PCTs.

### 7.3 What organisation and governance design principles are used by organisation level directors and managers?

Given their different tasks and natures, we need to discuss separately the organisational design approaches we found within acute trusts and PCTs.

In the acute Foundation Trusts, the key organisational recipe underpinning the devolved accountability and governance of the trust as a whole was that of the clinical care group or directorate. Under pressure from Monitor, trust boards have been encouraged and even required to ensure transparency and to report income and expenditure, profit and loss for each service line. At minimum, this means service line reporting, but there is additional pressure to develop this into service line ‘management’, i.e. active devolved managerial accountability, working in tandem with devolved clinical direction, and even the creation of business units as ‘profit centres’ at clinical directorate level.

The responses from directors, senior managers and senior clinicians have been complex. Senior managers have been keen to promote transparency
and indeed to devolve accountability, but they have also been circumspect about devolving too much power. The kind of accountability they carry makes them nervous about devolving decision making unreservedly to lead clinicians. As a consequence, practice to date with regard to this potentially very significant change to health care governance at the operational level appears to be somewhat experimental and guarded.

We have found evidence of widespread adoption of the principle of service line management and indeed “profit centres.” The introduction of such business units has introduced a new tier to the cascade of governance. These units potentially become semi-autonomous governing entities; the extent to which they do so varies considerably in practice both between trusts and between different units within trusts. But all clinical directorates are subject to oversight mechanisms. They are held accountable by more senior trust-level management. A typical reporting structure is for each unit to report to a scrutiny or performance committee on a regular basis – perhaps every two months. This committee is typically Chaired by a NED and includes a Medical Director, an Operations Director and a Finance Director. At these meetings a scorecard of multiple measures and performance indicators for units are reviewed and discussed. Trends can be identified, any corrective measures identified and new targets set. In turn, the total set of measures and performance indicators across units are often made available to the trust executive on a regular basis. The net result can be a degree of sub-unit autonomy, when units are making or exceeding targets and making well supported cases for investments in new services, staff, facilities or equipment. For units whose performance is in question, such unprecedented transparency can provide more power to the board in directing how the sub-unit should staff, prioritise or otherwise manage its services, reinforced by the possibility of an enhanced gaze from Monitor and the CQC, the purchasers of services and the DH.

One important variation in how the devolved clinical business unit concept is being implemented is in terms of how cost data are mapped on to services and so how service performance and viability are evaluated. We found cases where quite radical approaches to mapping costs on to a patient’s journey through the various facilities of a hospital (using activity-based costing) have been adopted and other cases where costs are allocated on a simpler pro rata basis. As a result, one of the major controversies concerning the operation of devolved business units has been the reliability and meaningfulness of cost data, and the meaningfulness of income data for particular service lines. We found that clinical directors have often been enthusiastic about the idea of having devolved responsibility for financial as well as clinical performance, seeing this as compatible with their notion of medical professionalism. But at the same time they have often been highly questioning about the reliability of the income and expenditure data. It appears that clinical and managerial leaders at sub-unit level have found it most possible to engage positively with the “profit centre” concept when supported by expertise involving their staff in the use of process analysis and quality management techniques, often under the rubric of “lean thinking”. These allow staff to analyse “patient journeys”, and identify
where sources of failure or waste of resources occur, including threats to patient safety, as well as enabling them to identify how to improve the experience of patients and staff alike. Such techniques allow clinicians to develop performance targets consistent with their sense of clinical professionalism as well as being meaningful to managers concerned with removing unnecessary costs. In some leading cases the result has been a new sense of partnership in “running the business” between clinical directors and their general managers.

Overall, the functioning of performance management and risk assessment in a way that is convincing to the staff concerned, as well as to business unit level clinical directors and general managers is crucial to achieving genuine transparency of reporting and scrutiny at board committee level. Without sense-making at operational level, grounded in detailed work on how to calculate costs of procedures, and a shared understanding across clinical and managerial perspectives of what drives them, board level sense-making runs the risk of being superficial and fragile. To illustrate this point further and make connections with the issue of trust autonomy, the most convincing account of the development of strategy at trust level, in the sense of prioritising investment and developing services was in a Foundation Trust where performance management had been developing for several years within clinical directorates. This investment in service analysis at the operating level paved the way for clinical directorates to develop their own sub-strategies in terms of identifying services where they had “competitive advantage” to provide distinctive services or standard services at an advantageous cost, which could then be aggregated and further refined at trust level.

This crucial link between sense-making at board level and at the operating level is further borne out by our findings within PCTs, although our research did not reveal the presence of a consistent template for organising commissioning, analogous to the care group or clinical directorate template found in the acute sector. Our case studies in Inner London and the North West of England revealed significantly different models for bringing clinicians into decisions on clinical pathway redesign and the reshaping of services through commissioning.

In Inner London, practice based commissioning was organised largely separately from the mainstream of PCT level commissioning. The latter had its own set of commissioning forums where PCT commissioning managers drew on the expertise of relevant primary care and acute clinicians. In the North West case, PBC was organisationally subservient to wider PCT decision-making on commissioning, but GPs representing PBC clusters were influential in shaping PCT level commissioning strategy. In other words, the organisation of decision-making in the North West encouraged managers and clinicians alike to take a more comprehensive view further along the length of clinical pathways. There was evidence that this was already leading to more explicit initiatives, sanctioned at board level, to rethink clinical pathways in the North West. This was recognised as a highly successful PCT.
This further illustrates our contention that strategic originality and capability at board level needs to be supported by multi-disciplinary analysis and sense-making at operational level. Bringing GPs and commissioners together in commissioning forums makes it easier to integrate them also into strategy shaping and the development of effective local priorities and mechanisms for delivering them.

It is also significant that in both the Inner London and the North West of England PCTs, one of the major board level preoccupations was with confusions experienced in the governance of services commissioned for vulnerable target groups by the PCT and local authority working in strongly espoused partnership. Both PCT boards expressed frustration at the lack of effective joint work in setting targets, allocating budgets and reviewing performance, with political negotiation between the separate preferences of the two commissioning bodies replacing interdisciplinary debate and learning. Our interpretation of this state of affairs is that it reflects a still early stage of integration between social care and healthcare providers at the operational level. When front line staff and their supervision have distinct priorities, spheres of concern, and preferred modes of intervening, it is difficult for a partnership board to take a more holistic view of the provision of care, how to measure it and set targets for improvement.

Governance is problematical. It is all the more difficult to decide how to intervene to achieve these improvements. The implication is that integration needs to be developed in parallel at both operational and strategic levels.

7.4 **What perceptions do healthcare staffs have about the new governance arrangements and how are they responding?**

As noted in the body of the report, our exploration of staff perceptions was mainly restricted to senior clinical staff and departmental general managers. This included clinical directors, other consultants and senior nurses.

We explored with these staff their perceptions and responses at three levels. First, their responses to macro-level NHS governance changes including the implications for inter-organisational working. Second, their responses to trust level governance – mainly, their understanding of the work of the board and their engagement with committees and other means to receive communications and to exercise voice. Third, their responses to devolved governance arrangements; here we mainly focused on their responses to strategic business units and service line management.

Staff responses to macro-level changes to NHS governance were mixed. About half the respondents were sceptical about ‘reforms’ and ‘modernisation’. They articulated a position which suggested that many reform packages over the past couple of decades had been primarily ‘political’ in intent. By this they meant the underlying rationale was informed less by medical considerations as the determining criterion and more by party political advantage. Part of this stance was explained as stemming from their experience of political parties as switching their
priorities after giving guarantees they would not. We found that staff were not necessarily opposed to particular polices or even collections of policies but rather they located themselves as relatively detached and relatively powerless and thus tended to adopt a stance as critics on the sidelines. As others have found before us, part of this was wrapped-up in a notion of ‘initiative fatigue’. Another element – also noted of course by others – was the familiar idea that initiatives were both transient and to some extent circular. Constant reference was made to the reforms of the early 1990s under the Conservatives and their ‘rediscovery’ and reinvention by Labour in some new form.

A significant proportion of senior staff within the acute trusts (both FT and non-FT) did not think the national polices and pressures were the product of well-considered and well-based theories of the organisation of healthcare. Rightly or wrongly many staff considered some recent government initiatives as flawed and ill-considered. In a number of cases they saw inconsistency, contradictions, ideology and opportunism as drivers of policies. While not being, in principle, against change (nearly every respondent in this study, when asked, eagerly and easily volunteered numerous areas where change was necessary) they frequently insisted that particular initiatives and policies, many of which were very disruptive and expensive, seemed to lack clear and acceptable justification. At the very least this suggests a communication gap. While much attention was focused on communicating the policy and its implications, there was far less emphasis on communicating the rationale of the policy and the theory on which it was based.

At the trust level, the predominant mode of response from staff (doctors and nurses) who were not themselves in attendance at the trust board, was to say that they had relatively little knowledge of business conducted by, and at, the board. Even fewer made reference to the board of governors in the cases which were Foundation Trusts despite the presence of staff representative on the bodies. Thus, once again, a common stance, rather similar to the one regarding national level governance, was to claim that the trust board – and the board of governors or members council - was relatively distant and detached and that real clinicians simply pressed on with the clinical work. Indeed, some senior hospital doctors made it clear that their preferred model was that senior managers and directors would take care of the administrative burdens in a manner that would ‘facilitate’ the conditions to allow clinicians to get on with the important work. This then was one mode of response to ‘governance’. It is a perception built on the idea of a servant function for governance with the attendant idea that it works best when it is least troublesome and interfering. The converse of this is that poor governance from this perspective is viewed as meddlesome, overweight, costly and demanding of information. This response to governance was at times as much directed at the concept of ‘clinical governance’ as it was at other forms. There was still some residual belief in the idea of the autonomous individual professional. Offsetting this was a seeming growing acceptance of the idea that clinicians now had to
demonstrate safe and proper practice by participating in peer oversight and review.

In a proportion of cases, senior clinician confidence in their boards was low and so too their confidence in the Department of Health. These sceptics tended to look to their boards for ways of mitigating what they perceived as the adverse consequences of DH policies. The ‘deep-clean’ policy in response to an increase in MRSA was frequently critiqued cited by clinicians and by senior managerial staff. In the worst cases, external pressures paradoxically produced internal responses which obstructed internal interest in necessary and desirable changes. And they even drove the further disengagement of clinicians in broader hospital governance issues. Since these pressures in some cases induced a crisis in hospital management this resulted in a style and regime of management (top-down, finance-focused) which resulted in many clinicians losing confidence in hospital governance and management and induced disengaging from involvement in, or responsibility for, broad-scale hospital-wide issues.

Numerous stories were told by senior clinicians and indeed by divisional general managers of how ‘the centre’ (i.e. the trust senior team) had tried to intervene to cut costs or to reshape services and how the imposed ‘solutions’ had been shown to be so badly wrong and counter-productive. On many of these occasions the centre-led or centre-imposed changes had been handled by external management consultancy firms and the clinicians were keen to show how these firms’ lack of understanding of clinical practice had led to the damaging outcomes. Finally, as we illustrated in the Riverside NHS Foundation Trust case, senior clinicians were critical of their trust boards where they judged that an overly-commercial and competitive stance was being adopted resulting in a barrier to cooperation and cross-boundary collaboration and learning among clinicians.

Staff perceptions of governance at the third level – that is, devolved governance to strategic business units or service lines – was rather different from those found at the previous two levels. Here, we found a very positive and indeed enthusiastic response. Given the attitudes described in the previous paragraph this response is not too surprising and is indeed consistent. We found that many senior staff welcomed devolved governance to strategic business units or clinical business units which were led by clinicians who were responsible for not only the clinical issues but also the business aspects of investments, profits and loss.

In general, senior clinicians were very willing to aspire to taking on these roles as unit or service line leaders. This may signal an important cultural shift. The bolstering of the clinical directorate concept gives further impetus to the idea of using clinicians to manage other clinicians. In the past, however, such attempts have sometimes been seen as subverted by senior clinicians who took on such roles in order to ‘protect’ rather than change traditional practices. It was even suggested that under earlier versions clinical directors appropriated the language of ‘service quality’ in order to defend the status quo and to negotiate more resources (Whittington, et al.
1994). Whether this is a ploy which could be repeated under today’s more complex and inter-locking governance regime is now a more open question.

Some of the elements of the policy reforms in the past few years have been talked about, and to a degree launched, before. The meta-narrative has been of a shift from a centralist, producer-led service to a devolved patient-focused service. ‘Accountability’, ‘choice’, ‘challenge’ (through multiple providers), and a quasi market subject to independent regulation have been the key watchwords and enabling devices. In previous instances the changes have generally been judged as of limited success, not least because they have failed to engage clinicians. But, as we have indicated, there are some signs that things may be different this time around.

There are a number of indications of such difference. The scale of the change and the multi-layered nature provides a set of mutually-reinforcing drivers. There is considerable professional managerial expertise within the system. Monitor and other bodies have recruited senior managerial staff with high levels of talent and produced tools for strategy making and operational management which are highly relevant to health care. Attempts to persuade many trust boards and management teams to adopt them are proving successful. The Appointments Commission has taken steps to ensure that persons appointed to Chair and NED positions in trusts are of high calibre and who broadly share the values of the change programme. Some medical directors in the larger trusts have taken on full-time roles as director-managers and have relinquished their clinical practice entirely; others are now working fifty per cent of their time as divisional clinical directors.

Of course, despite the number committed to the role who have the calibre to fulfil it, there will be others whose attitudes more closely reflect those found in previous studies – ambivalent, essentially committed to the clinical role, reluctant to manage other clinicians and so on - (Dopson 1996; Ferlie, Pettigrew et al. 1996; Hoque 2004; Pollitt, et al. 1991).

However, this time around, there are a number of key differences. One is that those trusts which are leading the change are taking steps to remove these less committed consultants from clinical director roles. They are only able to do this because they have located enough consultants who can and are willing to undertake the role in the fuller sense. It is true that there is no surfeit of these candidates but it is significant that there are beginning to be at least enough. Much hinges on how much influence they are truly allowed. Whilst many remain sceptical about the extent of devolved autonomy, there were fewer signs of ambivalence about the desire to achieve it. This contrasts with previous studies which placed emphasis on the strong identification with their profession (Pollitt, et al. 1991; Hoque 2004). There will of course still be some examples of the latter, but they seem less in evidence in the lead trusts which are pushing ahead with the service line management concept. The allure of spending a proportion of retained surpluses, and the exemplar of divisions and directorates which have invested in new ventures, brought-in new clinical teams and initiated new services, are proving powerful magnets.
Moreover, as noted above, some of the leading clinicians who are championing the drive to clinical directorate autonomy are in advance of their chief executives and operations director colleagues. They are prepared to play the long game – they are aware that consultants are in post for decades whereas they see chief executives come and go. Moreover, unlike previous studies, it seems these lead clinicians are not in thrall to their professions and Royal Colleges. In other words, while few in number there appears to be an emerging ‘new breed’ of medical director – a small group of actors who are marking-out new and uncharted territory. Individual actors – including chairs of boards and chief executives - are often critical of particular strands of the reforms but few claim to be able to offer comprehensive alternatives to the overall pattern. Quality of service, a focus on improving the patient experience, allied with accountability for financial probity and the efficient utilization of resources, overseen by regulatory authorities - is a formula which seems hard for these practitioners to contest.

Despite the many academic research reports in the 1990s reporting the lack of commitment by doctors to managerial roles (for example, Weightman 1996; Dopson 1996), there are increasing numbers of senior consultants eager to shoulder directorate lead roles in order to, as they put it, wield much greater influence beyond individual patients to whole patient groups through redesign of services and the allocation of resources. Indeed, as we reported above, the more pressing issue appeared to be the reluctance of senior managers to let go. In their single case study of a middle range trust, Hoque et al found little desire for autonomy either from the trust senior managers or from the consultants, indeed they state ‘there was no desire for autonomy’ (2004: 373). The situation now seems very different. Numerous chief executives and chairs appear very much to want autonomy for their trusts – not least because they wanted to escape the clawing back of surpluses by the SHAs. Likewise, medical directors and clinical directors seem very much to desire autonomy for their departments and divisions.

Summary

During the period of the study up to and including early 2009, the idea of devolved governance to service lines appeared to be spreading and gaining acceptance in the acute provider sector. The indicators we have noted suggest that the plethora of new governance arrangements – including institutions, mechanisms, cultural expectations, skill sets, carefully selected post-holders and governance pro-forma (exemplar agendas, information requirements and designated sources of information, annual meeting cycles guidance etc) backed up with a capable and powerful regulatory bodies – are now showing signs of impact. Similarly, the renewed emphasis on PCTs as commissioning bodies, with active involvement of GPs is commissioning, is being seized on with some alacrity by managers and senior clinicians alike in the primary care sector. As bridgeheads in both parts of the NHS become established, demonstrated and rewarded, other trusts may be pulled along behind to a degree not so far experienced previously.
Sources of isomorphism can be discerned. First, there is the necessity to satisfy the regulatory bodies. Trusts must pay close attention to the published standards and the pro-forma toolkits. Second, in order to handle the detail, trusts today commonly hire management consultants to advise and these bodies carry similar models and ways of operating from trust to trust. Third, the governance reforms have created a number of market-imitating conditions which tend to prompt like-minded behaviour between the trusts.

These forces are not necessarily inimical to the pioneering examples we cited above. Indeed, if the demonstration case could be placed on a secure footing, these institutional mechanisms could be used to drive the model through the system in an upward spiral. The intent to curb and check producer dominance and to drive innovation and efficiency has been pursued in numerous ways: through the use of market and quasi-market mechanisms – competition, choice and challenge; through new modes of accountability to users through user involvement and governing bodies; through targets, auditing, performance measures and league tables through direct regulation by the state; through the elevation of managerialism; through peer pressure underpinned by various forms of partnerships such as SHA’s using collaborative working groups of chief executives to reconfigure services and to close less viable services. Thus, in total, governance in the NHS represents an array of governance devices which draw freely on market, hierarchy and network principles. Interpreting these multiple messages and navigating a way through them is the interpretative task now facing the key actors such as directors and clinicians. Our research has indicated that one of the key requirements for achieving this is matching managerial with clinical sense-making about risk and performance at board level and at the operational level, so that performance reports reaching the board have coherence.

Such governing from afar is not without its tensions and challenges. The empowered chief executives do not merely pursue approved goals; they also tend to become obdurate defenders of their institutions which can make reconfiguration of wider health economies more difficult. Encouraging an emphasis on seeking competitive advantage in the provision of services can discourage collaboration between providers, and may encourage providers to behave opportunistically with respect to purchasers. Likewise, the enthusiastic medical director or clinical director advancing the cause of their own highly-functioning “profit centre” may be perceived as an obstacle by trust boards. But, these tensions are all part of the system in so far as a departure is made from a simple command and control mode of governance.

Two further challenges deserve mention. First, a regime of rigorous analysis of service performance in relation to user need requires new and better kinds of information, and skilled analysis of that information. More reliable data on public health needs, on the impact of particular preventative and curative health initiatives, and on the costs of different options for organising car pathways are some of the priorities currently emerging.
Second, returning to governance in the sense of what the board does, we found repeated concerns about defining effective roles for non executive directors and their relationship to improving community engagement. In Foundation Trusts, many NEDs felt torn between the corporate and business focus required for their board role and a wish to enter into the community or public interfacing work now apparently earmarked for FT members and governors. On the whole, for NEDs and indeed for FT boards as a whole, the focus on the health of the business seems to have won out. Community engagement is largely carried out through meetings of the governing body and members’ meetings, often more in the spirit of the kind of corporate public relations or social responsibility programme that a progressive private sector corporation would undertake. In PCTs, many NEDs struggled similarly with restraining their desire to raise particular instances of poor service and delve into operational details on services of special concern to a constituency they felt they represented – the elderly, the physically disabled, or a particular ethnicity. They felt that they should restrict themselves to commenting on and interrogating executive strategies and reports on the basis of the necessarily partial information available to them. They shared with their executive colleagues a sense of frustration as to precisely how a PCT should further develop its community engagement repertoire, struggling to integrate a set of new initiatives including public meetings, focus groups, and “mystery service users”.

Finally, it is worth referring back to a finding from our national surveys: boards which appeared to give a balanced voice to clinical and non clinical perspectives, with a moderately directive chief executive, appeared to be most effective in delivering according to the accepted performance indicators. This suggests that sense-making concerning the integration of clinical and non-clinical perspectives, and also strategic and operational concerns, is a collective endeavour. Those boards that have made most sense of their own strategic goals and how to deliver them, and thereby achieved some distinctiveness and locally meaningful effectiveness have done so through dialogue. Overall, there is much evidence that governance will not get easier; but it may become on balance more productive and innovative.

**7.5 Implications for better practice**

Foundation Trusts have perhaps the most complicated accountabilities in the NHS. When legislation was enacted it was envisaged that the vertical accountability to the elected governors would in some sense replace the vertical relationship with DH (via SHAs) and allow the umbilical cord with the Secretary of State for Health to be cut. In practice, this relationship is very weak, leaving a gap. This has largely been filled by Monitor. Established as an independent body charged with authorising Foundation Trusts, Monitor has actually taken a proactive approach to managing the performance of Foundation Trusts and intervenes to provide support to boards when Foundation Trusts are found wanting, although until very recently this has been confined to financial performance. The renewed focus on quality set out in *High Quality Care For All* requires that NHS
organisations are not only held to account for how they spend money but also for the quality of the care they deliver. High profile failures of care which have been investigated by the Healthcare Commission and recently publicised suggest that the current accountability mechanisms have failed to ensure these issues are picked up and addressed by boards, commissioners or SHAs. The proposal that all providers of care should publish quality accounts in future is designed to ensure that the strength of accountability which applies to the Accounting Officer in NHS organisations (usually the CEO) for financial accounts applies to the quality of care as well. Similar efforts that have gone into holding NHS organisations to account for their financial performance need to go into holding them account for the quality of care. This will require greater clarity about the role of regulators (in particular Monitor and CQC) and other account-holders in this respect, otherwise there is a danger that quality will continue to fall through the gaps. This is a real opportunity to use NEDs more effectively. As we have reported, where NEDs exercised influence they generally made a positive impact on the use of resources (this was confirmed by the case studies and the national survey). If NEDs can be used to attend to the quality of care agenda more fully then this mode of governance can be substantially enhanced.

Some respondents judged that FTs have no more than a few short years to make the concept of Foundation work – for example, getting governors and others properly involved and representative. Otherwise the Foundation concept would be seen as having ‘failed’ and hence would probably return to direct control of the DH. In other words there was a sense that the various innovations and experiments in governance were still rather conditional and even fragile.

Governance and FT self-governance are, as we have seen throughout this report, negotiable and somewhat fluid concepts. The future looks uncertain. In response to incidents such as occurred at Mid Staffordshire, the government has indicated it may claw back powers from Foundation Trusts. Health minister, Ben Bradshaw17 told a Commons health committee hearing that the government is considering legislation so it can direct Foundation Trusts. The health bill before Parliament includes provision for FTs to be de-authorised under the government’s plans for unsustainable providers.

As for PCTs, they face a series of governance challenges as they evolve into purely commissioning organisations. They have to demonstrate that they can demonstrate value for money. The transaction costs of commissioning will become clear when the PCTs are commissioning only. Comparison will inevitably be made with their value added in comparison with the systems in Scotland and Wales.

PCTs will need to demonstrate that they can secure or develop the necessary competencies and authority to be the local NHS leaders in the face of even stronger FTs. In London, the degree of shared working in

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17 On 3 June 2009
specialists commissioning sectors and hubs suggest that reorganisation to fewer PCTs cannot be far away.

PCTs sit at an interesting governance crossroads. They are required to meet the immediate priorities of the SHAs, to translate central concerns into influence over FTs but also to secure services, in partnership with others, which meet the short and long term needs of their communities. Current planning horizons of 3-5 years do not sit easily with the need for investment in obesity, diabetes and depression which as diseases require long term planning. The tension for PCTs will be in building confidence and resolve to commission the right services in the right setting and then manage the consequences to acute providers or to develop exert greater influence over providers in a collaborative shaping of clinical pathways.

The relation with regulation and improvement is still immature as PCTs seek to reconcile assurance of compliance by providers within a contract regime, yet also marshall the expertise of provider’s clinicians. The design of pathways and models of care that will deliver preferred outcomes may require a development of “relational contracting” where parties trade on the basis of strong interdependencies. Boards will need to assume the mantle of ‘first line regulators’ to ensure the commissioning process represents their communities’ rather than vested historical interests.

The NHS is about to face considerable tightening of budgets and governance will need to move into difficult areas of disinvestment, prioritisation treatment, drug switching and best value studies in a much colder climate. This will challenge partnerships’, the positive engagement by clinicians and the (to date) rather passive response from FT governors. PCTs can expect more judicial reviews of their spending decisions and boards will need to be able to demonstrate the logic, consistency and reasonableness of the process – and the way in which decisions have been made.

In many ways, governance systems are in their infancy. The Intelligent Board series highlighted the need for focused and relevant information for boards. However, in practice, we found that analysis and support systems such as risk registers and board assurance frameworks are still unwieldy, silo’d in their use and incomplete. Often they do not have appropriate presence on the agendas of boards. Board members still complain of voluminous routine reports which fail to tell the story, lack analysis and insight. Agendas are unbalanced in favour of finance and activity over quality. Quality outcomes and partnerships and reputational issues are neglected until they become self-evidently troublesome.

7.6 Limitations of the study

The study, as extensive and intensive as it was over the three year period of the research, was confined to NHS England. Further, its focus was on governance in the NHS and there was little time or resources available to make comparisons with governance in private sector healthcare.

The national postal survey was groundbreaking in that it targeted virtually the whole population of directors of boards in the NHS thus allowing access
to the multiple perspectives of clinicians and non-clinical directors, chairs and chief executives, and non-executive directors. It was pioneering too in the way that the resulting data about governance seen from these perspectives were analysed alongside externally sourced data on performance measures derived from independent sources. Despite these advances and advantages, a limitation of this study that needs to be borne in mind is that the survey data provide mainly a snapshot of governance at one point in time. Offsetting that disadvantage to a certain extent was the more longitudinally based qualitative case research which extended over three years. The case research was conducted in a manner which took advantage of repeat interviews as we built strong and continuing relationships with the main case partners. Not only could emerging trends and initiatives be tracked as they unfolded but, additionally, we were able to operate in an iterative manner – back-tracking to earlier cases with new challenges and ideas as these came to light in later case work.

Despite attempts to delve deeply into the operational levels of as many case sites as possible, resources of time did not always allow the same degree of access to operational staff perceptions at each of the sites. Thus, while trust board level comparisons across the cases were robust and comparable, the operational level insights were necessarily more varied. To have researched operational staff reactions to the various governance initiatives in any fuller and systematic a way would have required a larger study. Despite this limitation, we did attempt to make systematic comparisons in selected cases and we believe that the results were reproducible across other trusts as far as we could tell.

### 7.7 Implications for research

In this final section the implications of the findings for future research are considered.

1. Starting with a wide lens, it can be noted that the overall compatibility balance between the different ‘principles’ and logics of governance are as yet uncertain. As a result of the accretion of different emphases to particular principles at different points in time, the extant system induces the key players in the system to act in ways which cope with elements of competition, elements of hierarchy and elements of collaboration. Each of these can be used to beneficial effect, but equally, there are times when the tension between them causes confusion for the players and can lead to sub-optimal behaviours and outcomes. The example of the Renal Unit at the Riverside NHS Foundation Trust was an example. Here, the originally cooperative relationship with the regional hub at Parkside became undermined as the Riverside Board sought to proscribe collaborative relations between clinicians once the new renal unit was under construction in order ‘to protect commercial interests’.

The future research agenda is implicit in the above analysis. There are five key sub-questions: (a) To what extent will executive and non-executive
board members of trusts seize the opportunity to act entrepreneurially to any significant degree or to what extent will they continue mainly to seek to meet external benchmarks? (b) To what extent will the centre – the Department and the NHS executive and, by extension, the SHAs – adapt their roles to accord with the new devolved governance? (c) To what extent will clinical directors of the new profit centres within trusts assume a new leadership role and help develop innovative and adaptive business units? (d) Will the new PCTs be able to adapt to their new commissioning role in a way which delivers the vision of a transformative agency for health at local level? (e) Will NEDs be able to extend their role more effectively into care quality issues?

2. Narrowing the lens somewhat, research is needed on the service gaps that may arise within regions as individual FTs compete for business which requires underwriting by one or more commissioners.

3. The governance challenges that emerge from partnership working emerged as an issue requiring further investigation. Many of the senior interviews – most notably the chief executives of PCTs – indicated that although they signed partnership deals with local authorities and others, they were often unhappy with the degree of ongoing substantive commitment from the partners and unhappy with the ongoing inter-agency governance arrangements.

4. Will the relative consensus on the new governance model survive a straightened financial regime and, indeed, a change of government? Either way, the insights offered through this in-depth investigation of the way actors at all levels in the system interpret and respond to governance arrangements of various sorts ought to prove invaluable for future policy-makers and researchers.
References


Lewis, R., Hinton, L. (2008) 'Citizen and staff involvement in health service decision-making: have NHS Foundation Trusts in England given
stakeholders a louder voice?’, *Journal of Health Services Research and Policy*, vol. 13, no. 1, 19-25.


### Appendix 1:

#### 1. Members of the Project Advisory Board

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steve Barnett</td>
<td>Chief Executive of the NHS Confederation</td>
</tr>
<tr>
<td>Sandy Forrest</td>
<td>Chief Executive NHS 24 (Scotland) formerly chief executive of CRE.</td>
</tr>
<tr>
<td>Professor Tony Goldstone</td>
<td>Director, Cancer Network NEL</td>
</tr>
<tr>
<td>Peter Mansell</td>
<td>Director for Patient Experience, National Patient Safety Agency</td>
</tr>
<tr>
<td>Philip Marsh</td>
<td>Director of Human Resources, The Open University</td>
</tr>
<tr>
<td>Dr Richard Mason</td>
<td>Consultant Radiologist</td>
</tr>
<tr>
<td>Sandra Meadows</td>
<td>Director at Saxonbury Ltd, Ex HR Director at NHS</td>
</tr>
<tr>
<td>Dr Lucy Moore</td>
<td>CEO, Whipps Cross NHS Trust</td>
</tr>
<tr>
<td>Sue Osborn</td>
<td>Ex CEO, National Patient Safety Agency</td>
</tr>
<tr>
<td>Sue Young</td>
<td>HR Consultant, Formerly Chair of Hambleton and Richmondshire Primary Care Trust, and co-Chair of the NHS UK Staff Council</td>
</tr>
</tbody>
</table>
Technical Appendix 1: PCTs

1. Questionnaire piloting and response rates

The survey instrument for PCTs was developed after the Acute Trust survey and was designed to be compatible as far as possible with the Acute Trust questionnaire. The existence of a shared core set of questions enables comparative analysis through the production of comparable organisational level datasets. The PCT questionnaire differs from the Acute Trust questionnaire through the introduction of a series of free text responses based around statements concerning key issues within the World Class Commissioning agenda and a final free text response enabling broader and unconstrained reflection on the issues raised within the questionnaire.

The pilot questionnaire was mailed out to 101 individuals, with a follow up reminder letter one month later; 23 responses were received at the pilot stage, a response rate of 22.8% (this is an acceptable rate for a postal questionnaire). In light of responses received, minor amendments were made to the questionnaire, particularly in respect of question 3.3. – the minor nature of such amendment enables the interleaving of both pilot and full rollout data into a single dataset. The amended questionnaire was sent out to 1905 individuals, and a reminder sent a month later to those who had yet to respond.

In total, including both pilot and full rollout stage, 669 responses were received from the sample of 2,006 individuals, representing an overall response rate of 33.3%.
2. Questionnaires

PCT Questionnaire – Pilot Version

Survey of PCT Board Members

This survey is about changing governance arrangements in PCTs

1. About you:
(Please note: information concerning your particular PCT or you as an individual will not, under any circumstances, be reported or revealed to other parties. All responses will be anonymised in subsequent analysis). All data is treated in a fully confidential manner.

<table>
<thead>
<tr>
<th>1.1. Name of PCT</th>
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<tbody>
<tr>
<td>1.2. Your Name</td>
<td></td>
</tr>
<tr>
<td>1.3. Your Position/Job Title</td>
<td></td>
</tr>
<tr>
<td>1.4. Your Email Address</td>
<td></td>
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</tbody>
</table>

2. Reforms and Regulators

2.1. Please indicate the extent to which you agree / disagree with the following statements.
(Tick one box per item)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1. It feels to me as though there is a clear and coherent logic to the recent reforms of the NHS</td>
<td></td>
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<tr>
<td>2.1.2. The number and extent of recent reforms of the NHS means that my PCT has to prioritise certain reforms over others</td>
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<tr>
<td>2.1.3. Recent reforms of the NHS have significantly changed patterns of behaviour in my PCT</td>
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</tbody>
</table>

If you have answered ‘Agree’ or ‘Strongly Agree’ to the above question (2.1.3), please indicate your response to this statement:

“These changes in patterns of behaviour have had a positive impact on my PCT.”
2.2. A number of NHS reforms appear to have impacted or potentially impacted on PCTs. Examples include Practice-Based Commissioning, World Class Commissioning, reconfiguration of PCTs, increased emphasis on PCT influence, raised expectations about PCT performance, new appointments – and there are others. In the next question we are interested in your assessment of which reforms (the above and/or others) have had most impact in practice:

The NHS Reforms which have most affected the operation of my PCT are: (state three in priority order).

1. 

2. 

3. 

2.3. Thinking about the priorities of external regulators as they relate to my PCT, please indicate the extent to which you agree / disagree with the following statements.
(Tick one box per item)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.1. The priorities of my PCT are the same as the priorities of the Strategic Health Authority</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.3.2. The priorities of my PCT are the same as the priorities of the Healthcare Commission</td>
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<tr>
<td>2.3.3. The priorities of my PCT are the same as the priorities of the Department of Health</td>
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<tr>
<td>2.3.4. Taken as a whole, the priorities of external regulators (e.g. the Department of Health, Healthcare Commission) give out ‘mixed messages’</td>
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</table>

3. Governance

3.1. Emphasis
Thinking about how your PCT operates in practice how would you rank the importance of the following elements? (indicate your opinion by circling the ‘1’ for the category that is most important, circle ‘2’ for the second most important and circle ‘3’ for the third most important)

<table>
<thead>
<tr>
<th>3.1.1. Public involvement</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.2. Financial viability</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.1.3. Service quality</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
3.2. Practice
Please indicate the extent to which you agree / disagree with the following statements.
(Tick one box per item)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1. The Chairmen-executives of my PCT exert a strong influence on its operation.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3.2.2. In my PCT, the Chief Executive in the main runs the show.</td>
<td></td>
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<tr>
<td>3.2.3. The priorities of the Chairmen-executives of my PCT are significantly different from those of the Chief Executive.</td>
<td></td>
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<tr>
<td>3.2.4. The views of the Clinical Executive Committee have significant influence on decisions made at Board level.</td>
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</tbody>
</table>

3.3. It is known that there are different types of boards. Judging by the way your board operates in practice which one of the following statements most closely reflects the reality?
(Tick one box to indicate your choice)

1. The NEDS and executive directors work in partnership to improve performance
2. The NEDS seek to oversee executives and to check on their performance
3. The NEDS seek to represent the interests of patients and public
4. The NEDS are used to bring-in external expertise

4. Performance Measurement

4.1. Thinking about your PCT, please indicate the extent to which you agree / disagree with the following statements. (Tick one box per for each statement)

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1. My PCT gives main emphasis to service quality indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.2. My PCT gives main emphasis to financial indicators</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4.1.3. My PCT tends to focus mainly on whatever performance measures are currently prioritised by external regulators (e.g. the Department of Health, Healthcare Commission)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4.1.4. The Chairmen-Execs my PCT prioritise the same performance indicators as the Chief Executive.</td>
<td></td>
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</tr>
<tr>
<td>4.1.5. The measures my PCT uses to monitor its performance are the same as those used by external bodies, e.g. Department of Health, Healthcare Commission</td>
<td></td>
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<tr>
<td>4.1.6. Performance indicators presented to the Board have sufficient breadth and depth to accurately reveal the true performance of my PCT</td>
<td></td>
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</tbody>
</table>
4.2. To assess the performance of my PCT the three most important indicators [used in practice] are: (please state three in priority order)

1. 

2. 

3. 

4.3. Thinking about the use of the ‘Annual Health Check’ as a way of summarising the performance of your PCT, please indicate the extent to which you agree/disagree with the following statements. (Tick one box per item)

| 4.3.1. The ‘Annual Health Check’ measures give an accurate assessment of the performance of my PCT | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |
| 4.3.2. The ‘Annual Health Check’ measure has the ability to reflect genuine and meaningful changes in the performance of my PCT | |

4.4. In terms of the operation of my PCT, how would you rate the usefulness of the ‘Annual Health Check’ in the following areas? (indicate your opinion by circling one number for each item. The numbers represent a scale of 1 to 5, where “1 = Of no use at all” and “5 = Extremely Useful”)(Tick one box per item)

| 4.4.1. Defining strategic priorities | Of no use at all | 1 | 2 | 3 | 4 | 5 |
| 4.4.2. Distributing resources | 1 | 2 | 3 | 4 | 5 |
| 4.4.3. Identifying weaknesses | 1 | 2 | 3 | 4 | 5 |
| 4.4.4. Identifying strengths | 1 | 2 | 3 | 4 | 5 |
| 4.4.5. Improving service quality | 1 | 2 | 3 | 4 | 5 |
| 4.4.6. Improving financial performance | 1 | 2 | 3 | 4 | 5 |
5. PCT re-organisation / key challenges.

This section concern the recent re-organisation of PCTs (if your PCT was not reconfigured please move directly to question 6)
Thinking about the re-organisation of your PCT, please indicate the extent to which you agree / disagree with the following statements. (Check one box per item)

<table>
<thead>
<tr>
<th>5.1. The re-configuration of my PCT will lead to a closer relationship between health, social care and emergency services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.2. The re-configuration of my PCT will lead to improved and better value services for patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>5.3. The re-configuration of my PCT will lead to better emergency planning with more resources to respond to major incidents and ensure service continues as normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
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<tr>
<td>-----------------------------------------------------------------------------------------------</td>
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</table>

<table>
<thead>
<tr>
<th>5.4. The re-configuration of my PCT will lead to more money for frontline services</th>
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</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
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</tbody>
</table>

6. Practice Based Commissioning

Thinking about your experience with Practice Based Commissioning, please indicate the extent to which you agree / disagree with the following statements. (Check one box per item)

<table>
<thead>
<tr>
<th>6.2.1. Practice Based Commissioning will result in ‘Better Services for Patients’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>6.2.2. Practice Based Commissioning will result in ‘Better Clinical Engagement’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
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</table>

<table>
<thead>
<tr>
<th>6.2.3. Practice Based Commissioning will result in ‘Better Use of Resources’</th>
</tr>
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<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
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<td>-------------------------------------------------------------------------------</td>
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<table>
<thead>
<tr>
<th>6.2.4. The PCT receives sufficient information from GP practices to enact Practice Based Commissioning effectively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
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<td>----------------------------------------------------------------------------------------------------------------</td>
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<thead>
<tr>
<th>6.2.5. GP practices in my PCT have the skills and resources to manage PBC effectively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6.2.6. Practice Based Commissioning will increase collaboration between GP practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

If you have additional thoughts about PBC please enter them here

........................................................................................................................................
........................................................................................................................................
7. ‘World Class Commissioning’

The DH has issued its vision for ‘World Class Commissioning’. With respect to each of the following key elements, what do you judge to be the main barriers or difficulties impeding their achievement in practice?

<table>
<thead>
<tr>
<th>Vision</th>
<th>Barriers/difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCTs assuming local leadership for healthcare of all kinds</td>
<td></td>
</tr>
<tr>
<td>Securing clinical engagement in service design</td>
<td></td>
</tr>
<tr>
<td>Evidence-based assessment of priority needs of population</td>
<td></td>
</tr>
<tr>
<td>PCTs stimulating &amp; innovating new market designs for healthcare</td>
<td></td>
</tr>
<tr>
<td>PCTs in close partnership with providers to ensure contract compliance</td>
<td></td>
</tr>
<tr>
<td>and continuous improvement</td>
<td></td>
</tr>
</tbody>
</table>
If you wish to add any further thoughts about any of the issues raised in this survey please write them below or email J.Storev@open.ac.uk

Finally, we are conducting a series of one-to-one discussions (telephone or face to face) with a sample of PCT directors. If you would like to participate in this please tick the box

Thank you for your participation.
PCT Questionnaire – Full Rollout Version

Survey of PCT Board Members

This survey is about changing governance arrangements in PCTs

1. About you:
(Please note: information concerning your particular PCT or you as an individual will not, under any circumstances, be reported or revealed to other parties. All responses will be anonymised in subsequent analysis). All data is treated in a fully confidential manner. We need this data in order to send our findings to you and in order to compare perspectives and responses across posts/jobs.

1.1. Name of PCT

1.2. Your Name

1.3. Your Position/Job Title

1.4. Your Email Address

2. Reforms and Regulators

2.1. Please indicate the extent to which you agree / disagree with the following statements.
(Tick one box per item)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree not Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1. It feels to me as though there is a clear and coherent logic to the recent reforms of the NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.2. Recent reforms of the NHS have significantly changed patterns of behaviour in my PCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.3. If you have answered 'Agree' or 'Strongly Agree' to the above question (2.1.3), please indicate your response to this statement 'These changes in patterns of behaviour have had a positive impact on my PCT.'</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.4. Our governance arrangements are now integrated (tick against each of the following three or write 'Don't Know')</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) for the commissioning role</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) for the provider arm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) for the Trust Board’s work as a whole</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.2. A number of NHS reforms appear to have impacted or potentially impacted on PCTs. Examples include Practice-Based Commissioning, World Class Commissioning, reconfiguration of PCTs, separation of the provider arm, increased emphasis on PCT influence, raised expectations about PCT performance, new appointments – and there are others. In the next question we are interested in your assessment of which reforms (the above and/or others) have had most impact in practice:

**The NHS Reforms which have most affected the operation of my PCT are:** (state three in priority order).

1. 

2. 

3. 

2.3. Thinking about the priorities of external regulators as they relate to my PCT, please indicate the extent to which you agree/disagree with the following statements. (Tick one box per item)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.1. The priorities of my PCT are the same as the priorities of the Strategic Health Authority</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.2. The priorities of my PCT are the same as the priorities of the Healthcare Commission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.3. The priorities of my PCT are the same as the priorities of the Department of Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.4. Taken as a whole, the priorities of external regulators (e.g. the Department of Health, Healthcare Commission) give out ‘mixed messages’</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Governance

3.1. Emphasis

Thinking about how your PCT operates in practice, how would you rank the importance of the following elements? (Indicate your opinion by circling the ‘1’ for the category that is most important, circle ‘2’ for the second most important and circle ‘3’ for the third most important)

<table>
<thead>
<tr>
<th>3.1.1. Public involvement</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.2. Financial viability</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.1.3. Service quality</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
### 3.2. Practice

Please indicate the extent to which you agree / disagree with the following statements.

(Tick one box per item)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1. The Chair/non-executives of my PCT exert a strong influence on its operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.2. In my PCT, the Chief Executive is the main man; the show</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.3. The priorities of the Chair/non-executives of my PCT are significantly different from those of the Chief Executive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.4. The views of the Clinical Executive Committee have significant influence on decisions made at Board level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.5. We have made notable progress to meet the challenge of governance between organisations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3.3. It is known that there are different types of boards. Judging by the way your board operates in practice please indicate the extent to which you agree / disagree with the following statements. (Tick one box per item for each statement)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.1. The NEDS and executive directors work in partnership to improve performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3.2. The NEDS seek to oversee executives and to check on their performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3.3. The NEDS seek to represent the interests of patients and public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3.4. The NEDS are used to bring in external expertise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Performance Measurement

4.1. Thinking about your PCT, please indicate the extent to which you agree / disagree with the following statements. (Tick one box per for each statement)

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1. My PCT gives main emphasis to service quality indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.2. My PCT gives main emphasis to financial indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.3. My PCT tends to focus mainly on whatever performance measures are currently prioritised by external regulators (e.g. the Department of Health, Healthcare Commission)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.4. The Chairmen-Uses my PCT prioritise the same performance indicators as the Chief Executive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.5. The measures my PCT uses to monitor its performance are the same as those used by external bodies, e.g. Department of Health, Healthcare Commission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.6. Performance indicators presented to the Board have sufficient breadth and depth to accurately reveal the true performance of my PCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.2. To assess the performance of my PCT the three most important indicators [used in practice] are: (please state three in priority order)

1. 

2. 

3. 

4.3. Thinking about the use of the ‘Annual Health Check’ as a way of summarising the performance of your PCT, please indicate the extent to which you agree / disagree with the following statements. (Tick one box per item)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3.1. The ‘Annual Health Check’ measures give an accurate assessment of the performance of my PCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3.2. The ‘Annual Health Check’ measure has the ability to reflect genuine and meaningful changes in the performance of my PCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.4. In terms of the operation of my PCT, how would you rate the usefulness of the ‘Annual Health Check’ in the following areas? (indicate your opinion by circling one number for each item. The numbers represent a scale of 1 to 5, where “1 = Of no use at all” and “5 = Extremely Useful”) (Tick one box per item)

<table>
<thead>
<tr>
<th></th>
<th>Of no use at all</th>
<th>Extremely Useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4.1. Defining strategic priorities</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4.4.2. Distributing resources</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4.4.3. Identifying weaknesses</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4.4.4. Identifying strengths</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4.4.5. Improving service quality</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4.4.6. Improving financial performance</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

5. PCT re-organisation / key challenges.
This section concerns the recent re-organisation of PCTs (if your PCT was not reconfigured please move directly to question 6). Thinking about the re-organisation of your PCT, please indicate the extent to which you agree / disagree with the following statements. (Check one box per item)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1. The re-configuration of my PCT will lead to a closer relationship between health, social care and emergency services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2. The re-configuration of my PCT will lead to improved and better value services for patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3. The re-configuration of my PCT will lead to better emergency planning with more resources to respond to major incidents and ensure service continues as normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4. The re-configuration of my PCT will lead to more money for frontline services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Practice Based Commissioning

Thinking about your experience with Practice Based Commissioning, please indicate the extent to which you agree / disagree with the following statements. (Check one box per item)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2.1. Practice Based Commissioning will result in ‘Better Services for Patients’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2.2. Practice Based Commissioning will result in ‘Better Clinical Engagement’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2.3. Practice Based Commissioning will result in ‘Better Use of Resources’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2.4. The PCT receives sufficient information from GP practices to enact Practice Based Commissioning effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2.5. GP practices in my PCT have the skills and resources to manage PBC effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have additional thoughts about PBC please enter them here


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7. ‘World Class Commissioning’

The DH has issued its vision for ‘World Class Commissioning’. With respect to each of the following key elements, what do you judge to be the main barriers or difficulties impeding their achievement in practice?

<table>
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<th>Vision</th>
<th>Barriers/difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCTs assuming local leadership for health care of all kinds</td>
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</tr>
<tr>
<td>Securing clinical engagement in service design</td>
<td></td>
</tr>
<tr>
<td>Evidence-based assessment of priority needs of population</td>
<td></td>
</tr>
<tr>
<td>PCTs stimulating &amp; innovating new market designs for health care</td>
<td></td>
</tr>
<tr>
<td>PCTs in close partnership with providers to ensure contract compliance and continuous improvement</td>
<td></td>
</tr>
</tbody>
</table>
If you wish to add any further thoughts about any of the issues raised in this survey please write them below or email J.Storey@cepm.ac.uk.

Finally, we are conducting a series of one-to-one discussions (telephone or face to face) with a sample of PCT directors. If you would like to participate in this please tick the box

Thank you for your participation.
3. Description of variables in organisational level data.

Aggregate indicators of governance

These are calculated in terms of the mean response per organisation from single question prompts, namely:

- Practice of the Chief Executive (ce_rts)\(^{18}\)
- Influence of the Non-Executives (neds_strong)
- Influence of Clinicians (clin_strong)
- Alignment of the Executives and Non-Executives (conf_align)
- Emphasis on service quality indicators (serv_emph)
- Emphasis on clinical indicators (clin_emph)

Composite indicators of governance

There are conceptually driven indicators formed through the combination of a series of question responses. These indicators were initially calculated at the individual level, with the cognate organisational figures represented by a mean score of each organisation. In more detail these indicators are:

Policy Coherence (pol_coh)

Policy Coherence refers to the perception of the external policy environment within which an organisation is situated. At one end individuals could perceive the external policy environment to be miasma of conflicting and/or incoherent messages, through which an organisation has to determine its orientation / strategies - policy messages are essentially noise. At the other end the external policy environment could be perceived as internally coherent and mutually reinforcing. The organisational challenge, therefore is simply to carry our policy in the most effective manner, not interpret it.

This figure was calculated by adding together the score for 2.1.1.rev (reversed polarity of 2.1.1.\(^{19}\)), 2.3.4 to give individual perception of coherence (min=2, max=10, midpoint=6). For the organisation, a mean of individual perceptions per organisation is calculated.

Other Directed (oth_dir)

Organisations are ‘other directed’ when their priorities / strategies / resource allocation are determined by external bodies. Conversely an

---

\(^{18}\) Terms in brackets indicate the summary variable name.

\(^{19}\) Numbers refers to the question number in the questionnaire.
organisation is ‘autonomous’ where it generates priorities internally irrespective of external messages. This measure creates a single indicator for those question that explore aspect of ‘other directedness’. The figure is calculated in the following manner:

Reforms (2.1.2) + Priorities (Mean(2.3.1+2.3.2+2.3.3)) + Performance Orientation (4.1.3) = Other Directed (min=3, max=15, midpoint=9). This gives individual perception of the ‘other directedness’ of the organisation. A mean value per organisation offers a summary figure for each organisation.

Utility of the Annual Health Check

Organisations are performance assessed by various bodies. Chief amongst these have been the Healthcare Commissions ‘star ratings’ which have become the Annual Health Check measures. Organisations can be oriented to these measures in terms of seeing then as valid, useful for strategic planning, internal assessment and performance enhancement.

Strategies, strategic priorities and resource allocation (mean 4.4.1, 4.4.2) variable name (hc_strat)

Internal Assessment, strengths and weaknesses (mean 4.4.3, 4.4.4) variable name (hc_sw)

Performance, clinical and financial (mean 4.4.5, 4.4.6) variable name (hc_perf)
4. Principal Components Analysis – Organisational Level Data.

The intention here is both to: examine the structure, in an exploratory way, within the set of organisational level variables; prepare for subsequent analysis via multiple regression. These purposes could be met either by Principal Components Analysis (PCA) or Factor Analysis (Principal Axis Factoring). Given the second objective above, PCA with its focus on the total variance within the data would seem slightly more appropriate (suffice to say, though, that Principal Axis Factoring would lead to almost identical results).

Entering the eleven organisational level variables (detailed above) into a Principal Components Analysis reveals a KMO measure of .681. Although the detail is not shown here, it would seem plausible to retain four or five components. The former represents 60% of the total variance (communalities: min .410 clin_emph; max .796 hc_perf) and the latter 68% (communalities: min .468 ce_rts; max .860 fin_emph). The component matrices after varimax rotation for both cases are shown in Table 1.

(a) Four components

<table>
<thead>
<tr>
<th></th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>pol_coh</td>
<td>-.147</td>
</tr>
<tr>
<td>oth_dir</td>
<td>.255</td>
</tr>
<tr>
<td>serv_emph</td>
<td>.319</td>
</tr>
<tr>
<td>fin_emph</td>
<td>.045</td>
</tr>
<tr>
<td>conf_align</td>
<td>-.015</td>
</tr>
<tr>
<td>neds_strong</td>
<td>.050</td>
</tr>
<tr>
<td>ce_rts</td>
<td>-.113</td>
</tr>
<tr>
<td>clin_strong</td>
<td>.293</td>
</tr>
<tr>
<td>hc_strat</td>
<td>.824</td>
</tr>
<tr>
<td>hc_sw</td>
<td>.800</td>
</tr>
<tr>
<td>hc_perf</td>
<td>.884</td>
</tr>
</tbody>
</table>
(b) Five components

<table>
<thead>
<tr>
<th>Component</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>pol_coh</td>
<td>-.133</td>
<td>-.684</td>
<td>-.231</td>
<td>-.118</td>
<td>-.248</td>
</tr>
<tr>
<td>oth_dir</td>
<td>.269</td>
<td>.670</td>
<td>-.140</td>
<td>-.104</td>
<td>-.059</td>
</tr>
<tr>
<td>serv_emph</td>
<td>.291</td>
<td>-.207</td>
<td>.743</td>
<td>-.018</td>
<td>-.016</td>
</tr>
<tr>
<td>fin_emph</td>
<td>.034</td>
<td>-.044</td>
<td>-.093</td>
<td>-.052</td>
<td>.919</td>
</tr>
<tr>
<td>conf_align</td>
<td>.021</td>
<td>-.201</td>
<td>-.240</td>
<td>-.805</td>
<td>-.049</td>
</tr>
<tr>
<td>neds_strong</td>
<td>.017</td>
<td>.156</td>
<td>.751</td>
<td>.193</td>
<td>-.071</td>
</tr>
<tr>
<td>ce_rts</td>
<td>-.103</td>
<td>.579</td>
<td>-.051</td>
<td>.003</td>
<td>-.346</td>
</tr>
<tr>
<td>clin_strong</td>
<td>.271</td>
<td>-.236</td>
<td>-.039</td>
<td>.757</td>
<td>-.120</td>
</tr>
<tr>
<td>hc_strat</td>
<td>.812</td>
<td>.117</td>
<td>.231</td>
<td>.085</td>
<td>.121</td>
</tr>
<tr>
<td>hc_sw</td>
<td>.799</td>
<td>.078</td>
<td>.014</td>
<td>.102</td>
<td>-.089</td>
</tr>
<tr>
<td>hc_perf</td>
<td>.879</td>
<td>.072</td>
<td>.096</td>
<td>.051</td>
<td>.082</td>
</tr>
</tbody>
</table>

Table 1. Component matrices (after varimax rotation) for the four and five component cases (loadings greater than .4 have been emboldened).

The major difference between these two alternatives is that component 2 in the 4-component case divides into two components (3 and 4) in the 5-component case; both show similarities to the set of components extracted from the Acute Trusts data\(^{20}\). Allowing for the absence of org_turb in the PCT data the 4-component version is the more similar. The major difference is that the two variables pol_coh and oth_dir now associate with ce_rts which itself is not strongly contrasted with neds_strong(reversed) as occurs in the acute case. In the interests of parsimony and comparability with the other data set we will prefer the 4-component alternative for the purposes of further analysis.

A brief interpretation of the components is as follows:

**Component 1** loads on: hc_strat, hc_sw, hc_perf and serv_emph

It would be surprising if the first three were not highly inter-correlated and load together, representing as they do perceptions of the usefulness and relevance of the Healthcare Commission’s Annual Health Check. The cross-loading of serv_emph is clearly plausible here.

C1: Positive attitude towards the usefulness and relevance of the Annual Health Check

\(^{20}\) This is detailed in the Technical Appendix for the Acute Trust analysis.
Component 2 loads on: neds_strong, clin_strong, conf_align(reversed)$^{21}$, serv_emph, pol_coh(reversed).

This essentially mirrors the second component extracted from the acute dataset but with a cross-loading of pol_coh(reversed).

C2: Alignment of Executives, Non-Executives and Clinicians / Service emphasis

Component 3 loads on: ce_rts, pol_coh(reversed), oth_dir,

This component can be taken as representing the influence of the Chief Executive although the loadings of pol_coh(reversed) and oth_dir complicate matters.

High values of the variable oth_dir represents a perception that priorities are highly influenced by external bodies (e.g. the Healthcare Commission). Low values of pol_coh would suggest that there is a perception that the external policy environment is consistent and coherent. It is therefore reassuring that these two variables load together with different signs.

C3: Chief Executive runs the show

Component 4 loads on: fin_emph, ce_rts(reversed) and clin_strong (reversed).

This component represents a perception of an emphasis on financial performance together with cross-loadings from ce_rts(reversed) and clin_strong(reversed).

C4: Finance emphasis

---

$^{21}$ See Footnote 9 in the next Appendix and the associated discussion regarding the interpretation of the components.
Technical Appendix 2: Acute Trusts

1. Questionnaire piloting and response rates

The first questionnaire generated in the project concerned Acute Trusts; this questionnaire was piloted with 122 individuals covering board members for ten randomly selected acute trusts – the questionnaire was designed to be appropriate for both NHS trusts and NHS Foundation Trusts. The pilot was used to ascertain indicative response rate and identify any problematic questions / issues with the questionnaire design. Questionnaires were issued with a covering letter giving an overview of the research and a reply paid envelope to facilitate returns. A response rate of 38.5% was achieved following one reminder. Response rates for a general survey of a national population can be very low. However, targeting a specific population on an issue of material interest should enhance response rates, and the achieved response rate for the pilot represents an acceptable figure. It is generally recognised that a further second reminder letter would be subject to diminishing returns and would not cause the spike in responses experienced with the first reminder.

Analysing the returned questionnaires led to some minor amendments of the instrument, including the addition of a couple of sub-questions. The structure and content of both questionnaires share such a degree of similarity that data produced from the pilot and full rollout questionnaires could be interpolated into a single dataset. The full rollout involved the issue of 1,929 questionnaires, with a reminder sent two months after the initial mailing. There were a number of RTS (Return to Sender) returns which have been removed from the figures. In total, 579 individual returns were received from the sample of 2,051 individuals, representing an overall response rate of 28.2% - for this type of survey this represents an acceptable response rate.

---

22 A number of the RTS responses were for the whole cohort of Non-Executives, the insertion of the term 'Non-Executive' in the address label and a re-mailing prevented faulty returns.
2. Questionnaires

Acute Trust Questionnaire – Pilot Version

Survey of NHS Trust Board Members

1. About you:
(Please note that information concerning your Trust and individual views will under no circumstances be reported or revealed to other parties. All responses will be anonymised in any subsequent analysis)

<table>
<thead>
<tr>
<th>1.1. Name of Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.2. Your Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.3. Your Position/Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.4. Your Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2. Reforms and Regulators

2.1. Please indicate the extent to which you agree / disagree with the following statements.
(Tick one box per item)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1. There is a clear and coherent logic to the recent reforms of the NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.2. The number and extent of recent reforms of the NHS means that my Trust has to prioritise certain reforms over others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.3. Recent reforms of the NHS have significantly changed patterns of behaviour in my Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have answered ‘Agree’ or ‘Strongly Agree’ to the above question (2.1.3), please give an example of one of the most significant changes in behaviour.
2.2 The NHS Reforms which have most affected the operation of my Trust are: (State three in priority order)

1.

2.

3.

2.3 Thinking about the priorities of external regulators as they relate to my Trust, please indicate the extent to which you agree / disagree with the following statements. (Tick one box per item)

| 2.3.1. The priorities of my Trust are the same as the priorities of the Strategic Health Authority | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |
|---|---|---|---|---|

| 2.3.2. The priorities of my Trust are the same as the priorities of the Healthcare Commission |
|---|---|---|---|---|

| 2.3.3. The priorities of my Trust are the same as the priorities of the Department of Health |
|---|---|---|---|---|

| 2.3.4. Taken as a whole, the priorities of external regulators give out 'mixed messages' |
|---|---|---|---|---|

3. Governance

3.1. Emphasis
Thinking about how your Trust operates in practice how would you rank the importance of the following elements? (indicate your opinion by circling the ‘1’ for the category that is most important, circle ‘2’ for the second most important and circle ‘3’ for the third most important)

<table>
<thead>
<tr>
<th>3.1.1. Democratic/Community Representation</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.1.2. Financial Viability</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.1.3. Clinical Excellence</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
</table>
3.2. Practice
Please indicate the extent to which you agree / disagree with the following statements.
(Tick one box per item)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1. The Chair/Non-executives of my Trust exert a strong influence on its operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.2. In my Trust, the Chief Executive in the main runs the show</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.3. The priorities of the Chair/Non-executives of my Trust are significantly different from those of the Chief Executive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.4. Clinicians have significant influence on decisions made at Board level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Performance Measurement
4.1. Thinking about your Trust, please indicate the extent to which you agree / disagree with the following statements. (Tick one box per item)

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1. My Trust gives main emphasis to clinical outcome indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.2. My Trust gives main emphasis to financial indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.3. My Trust tends to focus mainly on those performance measures currently prioritised by external regulators (e.g. the Department of Health, Healthcare Commission)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.4. The Chair/Non-execuents and the Chief Executive of my Trust prioritise the same performance indicators.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.5. The measures my Trust uses to monitor its performance are the same as external regulators, e.g. Department of Health, Healthcare Commission.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.2. To assess the performance of my Trust the three most important indicators are: (please state three in priority order)

1. 

2. 

3. 

4.3. Thinking about the use of ‘Star Ratings’ and the ‘Annual Health Check’ as a way to summarise the performance of your Trust, please indicate the extent to which you agree / disagree with the following statements. *(Tick one box per item)*

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3.1. The ‘Star Ratings’ and the ‘Annual Health Check’ measures give an accurate assessment of the performance of my Trust.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3.2. The ‘Star Ratings’ and the ‘Annual Health Check’ measures have the ability to reflect genuine and meaningful changes in the performance of my Trust.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3.3. The ‘Annual Health Check’ captures the performance of my Trust better than the ‘Star Rating’ system it has replaced.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.4. In terms of the operation of my Trust, how would you rate the usefulness of the ‘Star Ratings’ and the ‘Annual Health Check’ in the following areas? (Indicate your opinion by circling one number for each item. The numbers represent a scale of 1 to 5, where “1 = Of no use at all” and “5 = Extremely Useful”) *(Tick one box per item)*

<table>
<thead>
<tr>
<th>Of no use at all</th>
<th>Extremely Useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4.1. Defining strategic priorities</td>
<td></td>
</tr>
<tr>
<td>4.4.2. Distributing resources</td>
<td></td>
</tr>
<tr>
<td>4.4.3. Identifying weaknesses</td>
<td></td>
</tr>
<tr>
<td>4.4.4. Identifying strengths</td>
<td></td>
</tr>
<tr>
<td>4.4.5. Improving clinical performance</td>
<td></td>
</tr>
<tr>
<td>4.4.6. Improving financial performance</td>
<td></td>
</tr>
</tbody>
</table>
5. Key events

Over the last five years, which of these events has occurred within your Trust?
(please tick all those that apply and put in the year in which the event occurred - if the event has happened more than once, please enter the years that they occurred)

<table>
<thead>
<tr>
<th>Event</th>
<th>Tick if the event has occurred</th>
<th>Enter the year that the event occurred (or years, if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1. Change of Chief Executive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2. Change of Chair of the Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3. Being put under ‘Special Measures’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4. Significant external intervention in the running of the Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.5. Major organisational re-structuring</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Acute Trust Questionnaire – Full Rollout Version

Survey of NHS Trust Board Members

1. About you:
(Please note that information concerning your Trust and individual views will under no circumstances be reported or revealed to other parties. All responses will be anonymised in any subsequent analysis)

1.1. Name of Trust

1.2. Your Name

1.3. Your Position/Job Title

1.4. Your Email Address

2. Reforms and Regulators

2.1. Please indicate the extent to which you agree / disagree with the following statements.
(Tick one box per item)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1. There is a clear and coherent logic to the recent reforms of the NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.2. The number and extent of recent reforms of the NHS means that my Trust has to prioritise certain reforms over others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.3. Recent reforms of the NHS have significantly changed patterns of behaviour in my Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have answered "Agree" or "Strongly Agree" to the above question (2.1.3), please give an example of one of the most significant changes in behaviour.

2.2 The NHS Reforms which have most affected the operation of my Trust are: (State three in priority order)

1. 

2. 

3. 

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2.3. Thinking about the priorities of external regulators as they relate to my Trust, please indicate the extent to which you agree / disagree with the following statements.
(Tick one box per item)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.1. The priorities of my Trust are the same as the priorities of the Strategic Health Authority</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.2. The priorities of my Trust are the same as the priorities of the Healthcare Commission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.3. The priorities of my Trust are the same as the priorities of the Department of Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.4. Taken as a whole, the priorities of external regulators (e.g. the Department of Health, Healthcare Commission) give out 'mixed messages'</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Governance

3.1. Emphasis
Thinking about how your Trust operates in practice how would you rank the importance of the following elements? (indicate your opinion by circling the '1' for the category that is most important, circle '2' for the second most important and circle '3' for the third most important)

| 3.1.1. Democratic/Community Representation | 1 | 2 | 3 |
| 3.1.2. Financial Viability | 1 | 2 | 3 |
| 3.1.3. Clinical Excellence | 1 | 2 | 3 |

3.2. Practice
Please indicate the extent to which you agree / disagree with the following statements.
(Tick one box per item)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1. The Chair/non-executives of my Trust exert a strong influence on its operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.2. In my Trust, the Chief Executive is the main man/woman show</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.3. The priorities of the Chair/non-executives of my Trust are significantly different from those of the Chief Executive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.4. Clinicians have significant influence on decisions made at Board level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Performance Measurement

4.1. Thinking about your Trust, please indicate the extent to which you agree / disagree with the following statements. (*Tick one box per item*)

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1. My Trust gives main emphasis to clinical outcome indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.2. My Trust gives main emphasis to financial indicators</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.3. My Trust tends to focus mainly on those performance measures currently prioritised by external regulators (e.g. the Department of Health, Healthcare Commission)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.4. The Chairman/Exco and the Chief Executive of my Trust prioritize the same performance indicators.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.5. The measures my Trust uses to monitor its performance are the same as external bodies, e.g. Department of Health, Healthcare Commission.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.6. Performance indicators presented to the Board have sufficient breadth and depth to capture the performance of my Trust.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.7. My Trust makes significant use of comparative and/or benchmarking indicators generated by organisations external to the NHS (e.g. Dr Foster, CHKS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.2. To assess the performance of my Trust the three most important indicators are: (please state three in priority order)

1. 

2. 

3. 
4.3. Thinking about the use of 'Star Ratings' and the 'Annual Health Check' as a way to summarise the performance of your Trust, please indicate the extent to which you agree / disagree with the following statements. *(Tick one box per item)*

<table>
<thead>
<tr>
<th>4.3.1. The 'Star Ratings' and the 'Annual Health Check' measures give an accurate assessment of the performance of my Trust</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4.3.2. The 'Star Ratings' and the 'Annual Health Check' measures have the ability to reflect genuine and meaningful changes in the performance of my Trust</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4.3.3. The 'Annual Health Check' captures the performance of my Trust better than the 'Star Rating' system it has replaced</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

4.4. In terms of the operation of my Trust, how would you rate the usefulness of the 'Star Ratings' and the 'Annual Health Check' in the following areas? *(Indicate your opinion by circling one number for each item. The numbers represent a scale of 1 to 5, where “1” = Of no use at all” and “5” = Extremely Useful”)* *(Tick one box per item)*

| Of no use at all | Extremely Useful |
|---|---|---|---|---|

| 4.4.1. Defining strategic priorities | 1 | 2 | 3 | 4 | 5 |
| 4.4.2. Distributing resources | 1 | 2 | 3 | 4 | 5 |
| 4.4.3. Identifying weaknesses | 1 | 2 | 3 | 4 | 5 |
| 4.4.4. Identifying strengths | 1 | 2 | 3 | 4 | 5 |
| 4.4.5. Improving clinical performance | 1 | 2 | 3 | 4 | 5 |
| 4.4.6. Improving financial performance | 1 | 2 | 3 | 4 | 5 |
5. Key Events

Over the last five years, which of these events has occurred within your Trust
(please tick all those that apply and put in the year in which the event occurred - if the event has happened more than once, please enter the years that they occurred)

<table>
<thead>
<tr>
<th>Event</th>
<th>Tick if the event has occurred</th>
<th>Enter the year that the event occurred (or years, if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1. Change of Chief Executive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2. Change of Chair of the Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3. Being put under 'Special Measures'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4. Significant external intervention in the running of the Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.5. Major organisational re-structuring</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Description of variables in organisational level data.

Aggregate indicators of governance

These are calculated in terms of the mean response per organisation from single question prompts, namely:

- Practice of the Chief Executive (ce_rts)\textsuperscript{23}
- Influence of the Non-Executives (neds_strong)
- Influence of Clinicians (clin_strong)
- Alignment of the Executives and Non-Executives (conf_align)
- Emphasis on financial indicators (fin_emph) and
- Emphasis on clinical indicators (clin_emph)\textsuperscript{24}

Composite indicators of governance

There are conceptually driven indicators formed through the combination of a series of question responses. These indicators were initially calculated at the individual level, with the cognate organisational figures represented by a mean score of each organisation. In more detail these indicators are:

Policy Coherence (pol_coh)

Policy Coherence refers to the perception of the external policy environment within which an organisation is situated. At one end individuals could perceive the external policy environment to be miasma of conflicting and/or incoherent messages, through which an organisation has to determine its orientation / strategies - policy messages are essentially noise. At the other end the external policy environment could be perceived as internally coherent and mutually reinforcing. The organisational challenge, therefore is simply to carry our policy in the most effective manner, not interpret it.

This figure was calculated by adding together the score for 2.1.1.rev (reversed polarity of 2.1.1.\textsuperscript{25}), 2.1.2 & 2.3.4 to give individual perception of coherence (min=3, max=15, midpoint=9). For the organisation, a mean of individual perceptions per organisation is calculated.

\textsuperscript{23} Terms in brackets indicate the summary variable name.

\textsuperscript{24} ‘clin-emph’ is a replication of the ‘serv-emph’ measure used in the PCT analysis with a terminological move from ‘service quality’ to ‘clinical’ indicators.

\textsuperscript{25} Numbers refers to the question number in the questionnaire.
Other Directed (oth_dir)

Organisations are ‘other directed’ when their priorities / strategies / resource allocation are determined by external bodies. Conversely an organisation is ‘autonomous’ where it generates priorities internally irrespective of external messages. This measure create a single indicator for those question that explore aspect of ‘other directedness’. The figure is calculated in the following manner:

Reforms (2.1.3) + Priorities (Mean(2.3.1+2.3.2+2.3.3)) + Performance Orientation (4.1.3) = Other Directed (min=3, max=15, midpoint=9). This gives individual perception of the ‘other directedness’ of the organisation. A mean value per organisation offers a summary figure for each organisation.

Utility of the Annual Health Check

Organisations are performance assessed by various bodies. Chief amongst these have been the Healthcare Commissions ‘star ratings’ which have become the Annual Health Check measures. Organisations can be oriented to these measures in terms of seeing then as valid, useful for strategic planning, internal assessment and performance enhancement.

Strategies, strategic priorities and resource allocation (mean 4.4.1, 4.4.2) variable name (hc_strat)

Internal Assessment, strengths and weaknesses (mean 4.4.3, 4.4.4) variable name (hc_sw)

Performance, clinical and financial (mean 4.4.5, 4.4.6) variable name (hc_perf)

Organisational Turbulence (org_turb)

Organisational Turbulence refers to the extent to which an organisation has undergone key events that provoke or require significant changes in the way it allocates resources, makes decisions, changes in key personnel.

This is measured by number of events occurring under q5.1-5.5. These events are added to give a figure for individual report of organisational turbulence (minimum value=0, no maximum). A mean of this value is calculated for each organisation, a higher value indicates higher levels of turbulence.
4. **Principal Components Analysis – Organisational Level Data.**

For the reasons outlined in the previous Appendix, we entered the twelve organisational level variables into a Principal Components Analysis. The resulting Kaiser-Meyer-Olkin Measure of Sampling Adequacy is .657 meaning that this treatment of the data is appropriate. Five retained components represent approximately 66% of the total variance of the twelve variables (maximum communality .904 (org_turb); minimum communality .404 (pol_coh)). The component matrix following varimax rotation is shown in Table 1 where loadings greater than 0.4 have been emboldened (although values greater than 0.3 have been included in the interpretation).

**Table 1.** Component matrix following varimax rotation (loadings greater than .4 are shown emboldened).

<table>
<thead>
<tr>
<th>Component</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>pol_coh</td>
<td>-.514</td>
<td>-.028</td>
<td>.185</td>
<td>.173</td>
<td>.273</td>
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<tr>
<td>oth_dir</td>
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<td>-.010</td>
<td>.255</td>
<td>.009</td>
<td>.038</td>
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<td>clin_emph</td>
<td>.038</td>
<td>.819</td>
<td>.137</td>
<td>.248</td>
<td>-.088</td>
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<tr>
<td>fin_emph</td>
<td>.053</td>
<td>-.038</td>
<td>-.017</td>
<td>.929</td>
<td>.043</td>
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<tr>
<td>conf_align</td>
<td>-.255</td>
<td>-.658</td>
<td>-.185</td>
<td>.234</td>
<td>-.175</td>
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<tr>
<td>neds_strong</td>
<td>.158</td>
<td>.656</td>
<td>-.446</td>
<td>.053</td>
<td>-.050</td>
</tr>
<tr>
<td>ce_rts</td>
<td>.013</td>
<td>.000</td>
<td>.927</td>
<td>.000</td>
<td>.001</td>
</tr>
<tr>
<td>clin_strong</td>
<td>-.014</td>
<td>.646</td>
<td>-.221</td>
<td>-.303</td>
<td>-.230</td>
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<tr>
<td>hc_strat</td>
<td>.736</td>
<td>.085</td>
<td>-.027</td>
<td>-.043</td>
<td>.054</td>
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<tr>
<td>hc_sw</td>
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<td>-.027</td>
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<td>hc_perf</td>
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<tr>
<td>org_turb</td>
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<td>-.090</td>
<td>-.008</td>
<td>.033</td>
<td>.946</td>
</tr>
</tbody>
</table>

The following identifies each component in turn concentrating on the large loadings (appearing in bold in the preceding table), offers limited commentary (where appropriate) and offers a short summary descriptor for each component:
Component 1 loads on: pol_coh (reversed), oth_dir, hc_strat, hc_sw and hc_perf.

It would be surprising if the latter three were not highly inter-correlated and load together, representing as they do perceptions of the usefulness and relevance of the Healthcare Commission’s Annual Health Check. Given that oth_dir represents a perception that priorities are highly influenced by external bodies (e.g. the Healthcare Commission) it might be expected that this variable would load similarly. High values of pol_coh would suggest that there is a perception that the external policy environment is a melange of conflicting and/or incoherent messages. Low values therefore suggest a perception of consistency/coherence. The reversed loading combined with the positive loading of oth_dir seems plausible.

C1: Positive attitude towards the usefulness and relevance of the Annual Health Check

Component 2 loads on: clin_emph, neds_strong, clin_strong and conf_align (reversed).

The first three of these loading together indicate a ‘coalition’ of Non-Executives and Clinicians pursuing a clinical emphasis. How does conf_align relate to these? In fact conf_align is typified by question 3.2.3

“The priorities of the Chair/non-executives of my Trust are significantly different from those of the Chief Executive”.

Low values of conf_align therefore signify disagreement with the statement and consequently suggest a measure of harmony between Executives, Non-Executives and Clinicians. The negative loading is therefore reassuring.

C2: Alignment of Executives, Non-Executives and Clinicians / Clinical emphasis

Component 3 loads on: ce_rts, neds_strong (reversed)

This component represents the influence of the Chief Executive in contrast to the Non-Executives.

C3: Chief Executive runs the show

Component 4 loads on: fin_emph and clin_strong (reversed).

This component represents a perception of an emphasis on financial performance.

C4: Finance emphasis

Component 5 loads on org_turb.

This component represents the extent of significant events (change of Chief Executive; change of Chair; being put under 'Special Measures'; significant

26 The term ‘reversed’ indicates a reversed polarity of the question in terms of its loading onto the component.
external intervention in the running of the trust; major organisational restructuring) occurring in the trust during the preceding five years.

C5: Organisational turbulence.

(These are trusts that are Excellent in at least one measure (and no worse than Good in the other) and trusts that are Weak in at least one measure (and no better than Fair in the other))

Table 2. AHC ratings for 2007 and 2008 regressed against the five principal components (C1 to C5) and dummy variable (Fndtn) for ‘extreme’ trusts.

(a) Quality of Services 2008 – $R^2 = .297$

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
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<th>Sig.</th>
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(b) Use of Resources 2008 – $R^2 = .666$

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(c) Quality of Services 2007 – R² = .606

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(d) Use of Resources 2007 – R² = .781

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Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.