Governing the English NHS : exploring the role and contribution of the Primary Care Trust Chair and Non-Executive Director

Governing the English NHS: Exploring the Role and Contribution of the Primary Care Trust Chair and Non-Executive Director

Joy Tweed, M.A.

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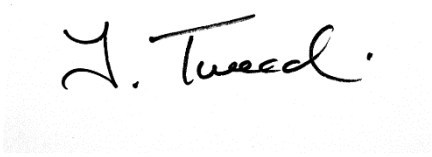
This is to certify that I am responsible for the work submitted in this thesis, that the original work is my own, and that neither the thesis, nor the original work contained therein, has been submitted to this or any other institution for a degree.



Joy Tweed

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Abstract

The area of research interest for this study was the governance role of non-executive directors (NEDs) and Chairs on NHS Primary Care Trust (PCT) boards across England. This interest arose from the experience of the author, herself a PCT NED, who was aware of some of the tensions of the role that resulted from a model of corporate governance and accountability imported from the private sector to the public sector. The NED role was more complex within PCTs as there were additional stakeholder expectations of providing public accountability. The changing policy landscape also saw NEDs responding to different Government priorities and developing the role in quite different ways to their counterparts in the private sector.

Newman's (2001) model of governance is a dynamic one that highlights the tensions caused by the Government's use of different types of governance mechanisms, seeking to achieve sometimes-conflicting goals. In this thesis the model is developed to consider how these tensions led to a differentiation of roles in practice for NEDs. The empirical analysis is based on interviews with 52 PCT NEDs and Chairs across England between October 2011 and April 2012. The dominant emphasis for some respondents was the efficiency of the organisation, reflecting principles of new public management and providing accountability to the taxpaying public. Other respondents saw their accountability as being to the local community and patients, and their role to defend these interests. They saw themselves as having a role both within and outside of the organisation, oriented towards a decentralised model of governance and working collaboratively with other stakeholders to improve health outcomes.

This study identified that the NED role as a defender of public interests provided a motivation to act, was a source of power and was one influence on the board as it tried to act within the tensions of operating as a local organisation, responsive to local need in addition to meeting nationally-determined targets.

Previous studies found the NHS NED role to be marginalised, but this study found PCT NEDs and Chairs able to exercise power to achieve results in line

with their interests, although their power was often constrained by the power of other actors, notably the Strategic Health Authorities acting on behalf of the Department of Health.

Even though PCTs have been abolished, the corporate governance model of a board and NEDs remains in hospital trusts and other parts of the public sector to the present day. The tensions between national and local accountability remain. This thesis provides support for a differentiation of NED roles, recognising the limitations of the new public management approach and a model of corporate governance from the private sector. While those NEDs with business expertise may be able to contribute to organisational efficiency, there is also a need for NEDs with a public service interest and the skills to influence and work collaboratively with stakeholders to ensure health services best meet the needs of communities.

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Acronyms and Glossary

CCG Clinical Commissioning Group, responsible for the commissioning of services after the abolition of PCTs.

CQC Care Quality Commission (the regulatory body that replaced the Healthcare Commission)

CEO Chief Executive Officer

DH Department of Health

GP General Practitioner

NED Non-Executive Director

NPM New Public Management

PEC Professional Executive Committee

PCT Primary Care Trust

SHA Strategic Health Authority

Appointments Commission. (Originally the NHS Appointments Commission). An arms-length body set up in 2002 to oversee the appointment and support of NEDs and Chairs, initially for NHS boards though later its role broadened. Abolished in 2012.

Healthcare Commission. A non-department public body in existence between 2004 and 2009. It provided an independent assessment of organisations providing health services. From 2006 each Trust had to declare its compliance with a number of core standards – the annual 'healthcheck'. Replaced by the Care Quality Commission.

World Class Commissioning Programme. This was introduced for PCTs in 2007 in an attempt to improve the PCTs' ability to commission services and improve health outcomes for its population. It set out to measure the performance of PCTs in three areas: health outcomes, governance and a number of competencies PCTs needed to achieve to be 'world-class' commissioners.

Chapter One: Overview

Since its creation in 1948, the National Health Service (NHS) in England has undergone a number of organisational changes (Ham, 2009). This study focuses on one particular development – the introduction of corporate governance practices imported from the private sector as part of New Public Management reforms in the 1980s. This, it was claimed, led to greater independence for local NHS organisations while remaining part of a centrally-organised, publically-provided service, and the strengthening of management arrangements within hospitals and health authorities through the introduction of private sector-style boards with non-executive directors.

While the adoption of corporate governance practices based on the private sector precepts and structures into the NHS has been questioned (Chambers *et al*., 2013; Ferlie and Ongaro, 2015), there are only a few studies that explore how managing and governing in the public sector may be fundamentally different (Cornforth, 2003; Chambers *et al*., 2013).

This study seeks to make a contribution to this field and has two broad areas of research interest: how do private sector corporate governance practices work in practice in the public sector, using the NHS as an example? And how do boards of public sector organisations, such as within the NHS, manage the tension of being nationally accountable while also being responsive to local need, where these national and local accountabilities may be in conflict?

These two areas of interest will be explored using the first-hand experiences of non-executive directors (NEDs) and Chairs on NHS Primary Care Trust (PCT) boards across England. More than three hundred PCTs were established in England in April 2002, with the responsibility of improving the health of their local population and the provision of health services. They were envisaged at their inception as local organisations whose aim was to bring budget and control closer to local communities and clinicians. However, they became increasingly subject to strong performance management from the Department of Health via the Strategic Health Authorities. One of their biggest challenges was how to

balance local priorities with central government ones, when there was sometimes overwhelming pressure to meet national targets (NHS Confederation, 2013).

At the commencement of this research it was not envisaged PCTs would be abolished. However, when the Coalition Government was elected in 2010, plans for a reorganisation of the health service in England were introduced and PCTs were abolished in 2013. Clinical commissioning groups are now in place, with a similar Government objective of transferring power to local organisations (NHS Confederation, 2013). While the governance structures of clinical commissioning groups are different to PCTs and have governing bodies with lay members, rather than boards, the experiences of NEDs and Chairs are relevant in considering how local, lay people can influence decisions. The model of a unitary board with NEDs and executive directors also remains in place in other parts of the NHS, such as NHS Trusts and NHS Foundation Trusts.

The two overarching questions of interest for this study therefore remain highly germane. How do local NHS organisations manage the tension between acting in the local interest, yet are required to meet national priorities, which may conflict with what is felt a local priority? And how do private sector corporate governance practices, in particular the NED role, work in practice within the public sector, using the PCT role as an example? These are important questions that are explored and examined in this thesis.

The rest of this chapter sets out the external context within which PCTs were created and some of the key policies that influenced their operation. The final section of this chapter sets out the structure of the thesis and, for expository purposes, gives an overview of the content and key findings of each of the chapters that follow.

1.1 Primary Care Trusts

The desire to modernise

When New Labour was elected in 1997, one key policy theme was the 'modernisation' of the NHS. The creation of PCTs was seen as part of this 'modernisation' wave, with the aim of bringing decision making closer to local communities and clinicians and with the optimistic expectation that local people would be enabled to engage in decisions about their local health services (Department of Health (DH), 2001).

In 2002 just over three hundred PCTs were established, although a few had already been running in pilot form. They replaced health authorities as the commissioners of care but also provided primary care through the services of primary care contractors such as General Practitioners (GPs), dentists, pharmacists and opticians. At their inception PCTs also provided community services, such as district nurses and children's health services.

Redistribution of power

The creation and implementation of PCTs signalled the Government's claimed intention to move the balance of power away from central government and towards frontline staff and their patients, reflecting a belief that services could be more responsive and shaped to local need. They were to be 'freestanding organisations' with greater flexibilities and freedoms compared to previous health organisations, with a large part of the NHS budget and responsibility for the provision of health services devolved to them (DH, 2001). The then Secretary of State for Health emphasised that PCTs' 'sense of direction is looking outwards to their locality not upwards to Whitehall' (Reid, 2003, p.14). However, an increasing number of centralised performance targets meant that, in practice, the PCTs' sense of direction was predominantly upwards, with direct hierarchical accountability to the Department of Health, via the Strategic Health Authorities (SHA).

The PCTs operated within complex governance and accountability arrangements. While traditionally models of 'governance' have been considered to take three forms: hierarchy, markets or networks (Thompson, 2003), there are many hybrid forms, particularly within the NHS. In markets, transactions between multiple producers and consumers are governed through price, but within the NHS the Government regulates this. Thus there is not a free market but, rather, a market that is highly regulated.

The Government has a role too in managing networks, which while traditionally may be based on more informal relationships or shared outlook, may include some hierarchical elements (Ferlie *et al.,* 2010). PCTs had a range of relationships, including direct-line management from the SHA, contractual relationships with providers of care, such as hospitals within a quasi-market and network-like arrangements with other health and social care organisations.

Accountability and performance management

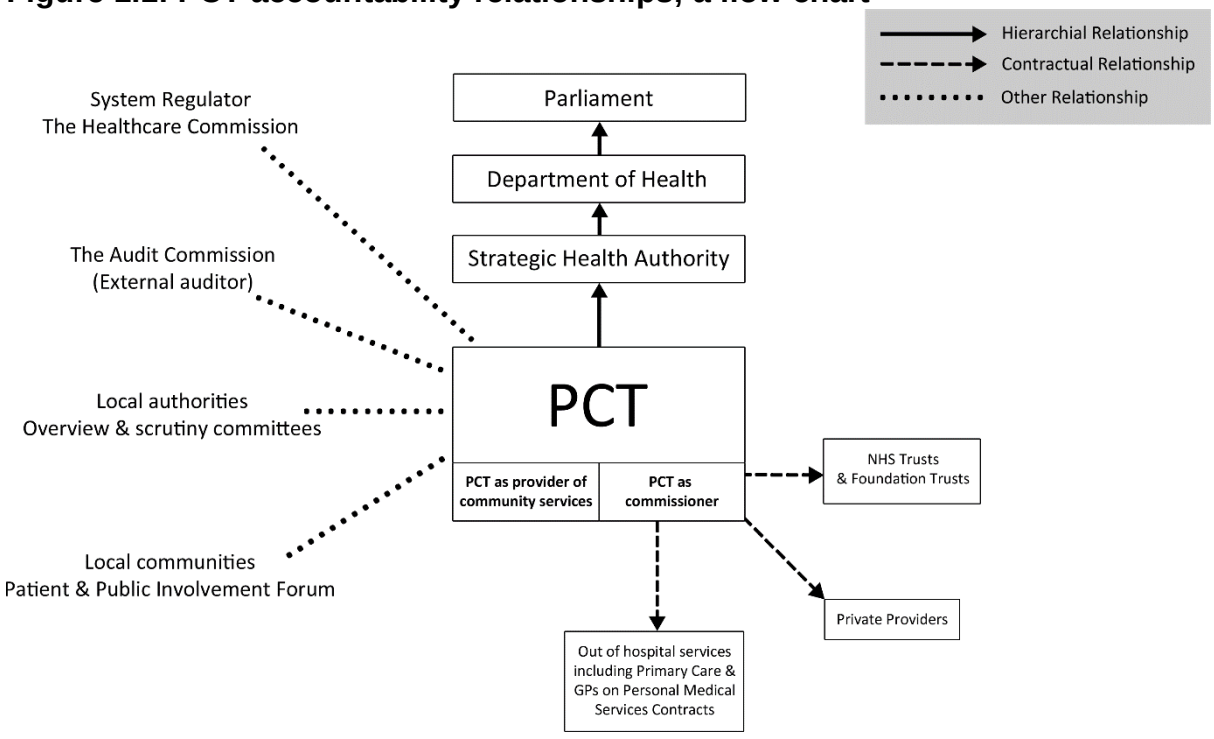
PCTs were also accountable to regulatory bodies and to the public. The NHS plan (DH, 2000) introduced performance management of all hospital trusts and expanded this from looking purely at financial aspects to include clinical performance, with the introduction of systematic clinical governance mechanisms into Trusts. New public bodies were set up to monitor and provide national guidance to the NHS, such as the National Institute for Clinical Excellence and the Commission for Health Improvement. PCTs were accountable to the latter, which later became the Healthcare Commission, for the quality of care provided and commissioned, and to the Audit Commission for financial management and accounts.

PCTs were expected to collaborate with patients and the public in deciding how health services were designed and delivered. The Bristol Royal Infirmary Inquiry (Kennedy, 2001) into paediatric cardiac deaths at the hospital recommended that patients should be at the centre of the health service, actively involved in decision-making. The Government, which had already begun a series of reforms to increase patient engagement in the NHS, accepted this principle.

The Health and Social Care Act c.11 (2001) placed a statutory duty on NHS institutions to involve and consult patients and the public in planning services; developing and considering proposals for changes in how those services are provided, and decisions that affect how those services are operated. Patient and Public Involvement Forums were set up in each PCT and NHS Trust in 2003, seen by the Government as the main vehicle for enabling the public to influence the management of the health service. PCTs were also accountable to the overview and scrutiny committee of the local authority, to whom it had to provide information and for the Chief Executive to attend meetings as requested.

The PCT operated within a web of complex relationships, with the major ones shown in figure 1.1. This shows the vertical accountability of PCTs to the SHA and through them up to Parliament. There were then contractual relationships with a range of providers of primary and secondary services. These might be provided by the NHS or the private sector, both for profit and not for profit. There was then a range of other accountabilities, such as to local communities, local authorities and regulators.

Figure 1.1: PCT accountability relationships; a flow chart



Public governance has been described as a multi-layered concept (Morrell, 2006; Stone and Ostrower, 2007) contingent on the actions of various actors required to both look up to the authorising environment and down to the operating environment. Figure 1 shows just how complex the operating environment was for PCTs and the number of sometimes competing accountabilities, of which the tension between acting as a local organisation meeting local need and as part of a national organisation – the NHS publically accountable to the taxpayer – is just one.

The PCT board was ultimately accountable for the actions of the organisation, and a key role of the board was in arbitrating between local and national priorities (Storey *et al.,* 2010). However, how the board undertook this arbitration of priorities and how local people, serving as NEDs, might have been able to contribute to the negotiation of interests has not been considered in any depth. Whether the model of corporate governance adopted from the private sector is able to meet the challenges of the public sector and what adaptations it has had to make in practice is an area of interest for this study.

Section summary

The creation of PCTs was part of a move to a more decentralised health service organisation, with the expectation that there would be greater responsiveness to local need and innovation, resulting in greater efficiency and more equitable provision (Exworthy *et al.,* 2010). This section has shown some of the different accountability arrangements within which PCTs operated, including hierarchical accountability to the SHA, and contractual arrangements with primary care and NHS Trusts. There were also a range of other expectations, such as increasing accountability to patients and the public through the introduction of Patient and Public Involvement Forums and health scrutiny powers for local authorities.

1.2 Governance arrangements within PCTs

The adoption of corporate governance practices into the NHS was just part of a range of policies influenced by the introduction of New Public Management

(NPM) practices into the public sector. This can be traced back to the report by Sir Roy Griffiths, who was tasked with improving performance and efficiency (Griffiths, 1983). He proposed an increase in the managerial role within the NHS, with an emphasis on accountability and performance management at the individual hospital and at health authority level. Further reviews of the NHS in the late 1980s led to the creation of the internal market, where the contracting out of functions was encouraged and quasi-markets introduced, allowing a choice of providers within a managed system (Bevir and Rhodes, 2006).

The role of Government in managing the operations of the NHS also changed, with hospitals in 1992 becoming self-governing NHS Trusts with their own board of directors. These were based on a business model of corporate governance, with a unitary board of both non-executive and executive directors corporately responsible for governance.

The PCT governance structure was different to other NHS Trusts and had specific requirements for board composition, set out in the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000.The board was to have between eight and 14 members, with between five and seven NEDs, and a NED Chair. Executive officers included the Chief Executive and the Director of Finance, plus the clinician Chair, and up to three other members, of the Professional Executive Committee, including a GP and a nurse. The Professional Executive Committee, a subcommittee of the board, was responsible for delivery of the clinical agenda and was designed to bring together clinical and managerial perspectives. While the PCT board could vary in size and other executive members be appointed, they were not allowed to be in the majority on the board.

The independence of the NED role across the NHS was strengthened through the introduction of an independent appointment body, the NHS Appointments Commission, which introduced a merit-based selection process for NEDs and Chairs to NHS Boards. The shortlisting of candidates and interviews were carried out jointly by both the Chair and independent members from the NHS Appointments Commission. This differed from previous practice within the NHS and also from corporate governance practice in the private sector.

The NED role for PCTs varied from the previous business model used within NHS Trusts. Potential NEDs and Chairs for the new PCTs had to meet certain competencies and live in the area covered by the PCT. The White Paper, *Shifting the Balance of Power within the NHS: Securing delivery* (DH, 2001) stated that PCTs were to be the 'most local NHS organisation and are led by clinicians and *local people'* (my emphasis) (p.13). The guidance reflects the idea that a solution to the problems of the NHS was a more-inclusive model of governance, bringing together local people and local clinicians to co-produce a locally responsive NHS.

An induction guide for Chairs and Non-Executive Directors (NHS Appointments Commission 2002) included little on corporate governance. Rather, the board was required to use a 'broad range of management skills… to deliver the Government's policies for healthcare in their organisation and for their community' (p.14). The NED was expected to use his or her knowledge of the local community to ensure that the interests of service users came first. PCT NEDs around this time were often seen as community representatives. The role of the NED was broken down into four roles as shown in table 1.1.

Table 1.1: The role of the non-executive (NHS Appointments Commission 2002, p.16)

Steward	Making sure that due process is followed to ensure the integrity of the NHS.
Ambassador	Acting as a two-way representative bringing the experiences, views and wishes of the community and patients to the board and representing the interests of the NHS organisation to the community.
Guardian	Ensuring that the strategic direction and policies of the NHS body is in accordance with national policy, ensuring a synergy between overall NHS values and those engendered locally.
Experience	Bringing life skills gained in the home, community or at work as well as particular professional or business skills to enhance the expertise of the board.

So the initial model for PCT boards envisaged a quite different role for the NED to that in the private sector. However, views on the role of the NED in PCTs rapidly changed, in part informed by the Higgs Report (2003). This review of corporate governance in the private sector emphasised the importance of independent directors on the board as part of good corporate governance practices.

Influence of the Higgs report (2003) on NHS boards

The Higgs report strongly influenced a guide for NHS boards, *Governing the NHS,* (NHS Appointments Commission and DH, 2003). In contrast to the earlier guide for NEDs, this emphasised the role of boards in governance, using the Audit Commission's definition of corporate governance: 'The systems and processes by which health bodies lead, direct and control their functions in order to achieve organisational objectives and by which they relate to their partners and the wider community' (p.7).

While the PCT NED role had previously been seen, in part, as bringing local knowledge to the board, the assurance aspect is now emphasised, with the NED role to ensure that the board acts in the best interests of patients and the community. NEDs were to encourage the cultural change within the organisations so that there was 'full engagement with patients, staff and local communities' (NHS Appointments Commission and DH, 2003, p.25). They were cautioned that they were appointed with a mandate to assist the board in governance rather than to act in a representative capacity. The time commitment expected from NEDs was reduced from five days a month to two-and-a-half, with the remuneration remaining the same. This reflected the expectation that the NED role was to focus on governance, with less operational involvement in different committees. It also effectively doubled the remuneration, which had been another pecuniary issue for some NEDs and broader stakeholders too.

Further guidance from the Department of Health (2004) made it clear that NEDs were not to be seen as representatives of the public or to be champions of patient and public involvement. Rather they were there to govern the

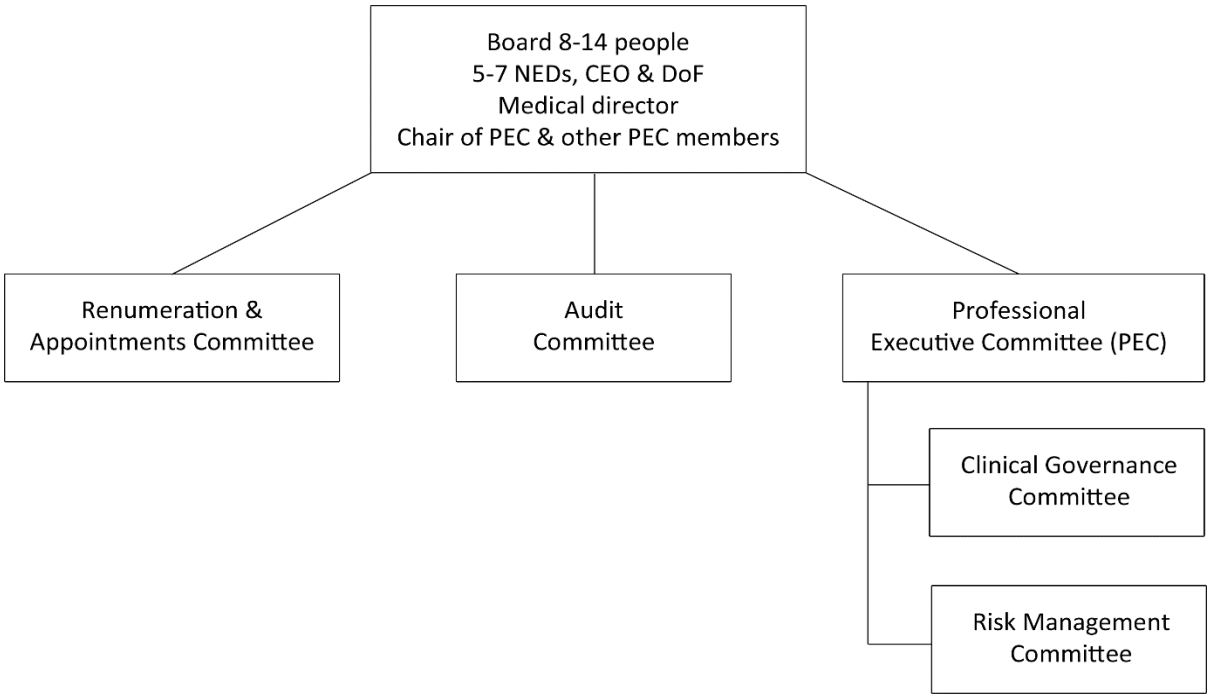
organisation and ensure that the board is held to account while also benefitting from constructive challenge to service improvements.

The PCT board and subcommittees

Each PCT had a number of statutory subcommittees, shown in figure 1.2. The audit committee was responsible for ensuring the organisation had effective systems of internal control and was required to engage with the work of internal audit and the external auditor. It consisted of three NEDs, with the Chair of the PCT not allowed to serve on the committee. The greater responsibility of the audit chair compared to other NEDs was reflected in the expected time commitment of five days per month compared to 2.5 days and accompanied by greater remuneration. The remuneration and appointments committee consisted of the Chair and two other NEDs. There was also a clinical governance committee, responsible for scrutinising and reviewing the systems in place to ensure, monitor and improve the quality of healthcare provided, and a risk management committee (NHS Appointments Commission and DH, 2003).

One major difference to other NHS organisations was the existence of the Professional Executive Committee, which reported to the board and had the major oversight for clinical matters. Membership included the Chief Executive and Director of Finance (DoF), a social services representative nominated by the local authority and up to 14 health professionals, but not NEDs. Although these were the statutory subcommittees at the time PCTs were established, many PCTs developed additional committees, such as finance or quality committees that NEDs chaired (Bullivant *et al.,* 2007).

Figure 1.2: PCT board subcommittees



The role of the PCT board

Each year the Operating Framework for the NHS would set out the Government's priorities for healthcare and the performance measures it expected NHS organisations to meet, such as waiting times for patients to see a GP or wait for treatment. NHS Trusts were required to break even financially every year, by virtue of Paragraph 2 (1) Schedule 5 of the National Health Service Act 2006. The expected roles of the board were to provide leadership and control, to set the strategic aims, and to set and maintain the organisation's values and standards (NHS Appointments Commission and DH, 2003).

Later, influential guides for boards expanded on these roles and set out to provide best-practice guidance, often drawing on research from the private sector. The *Integrated Governance Handbook* (DH, 2006) not only brought together the requirements for corporate governance but also clinical governance. The guide stressed the requirements of the board to meet NHS

performance targets and the role of an Assurance Framework to identify risks to the achievement of priorities, recommending an integrated assurance system.

The Intelligent Board (Appointments Commission and Dr Foster Intelligence, 2006a) was another source of guidance for NHS boards. It saw the function of NHS boards as being to 'add value' and not just cost to the organisation, and provide leadership within a framework of prudent and effective controls. The board was to set strategic direction, monitor performance, safeguard values and ensure the organisation's obligations to stakeholders are met (p.5). It argues that for effective board performance there is a need for the right information, the recommendations for which it sets out in the rest of the report.

The Intelligent Board was followed by others in the series, including *The Intelligent Commissioning Board* (Appointments Commission and Dr Foster Intelligence, 2006b). This saw the challenge to PCT boards as ensuring the 'commissioning and delivery of the best-quality healthcare to their communities, meeting national targets and standards, and staying within budgets' (p.25).

These reports were widely disseminated and used to inform governance in the NHS, in particular the recommendation that 60% of a board's time should be spent on strategy (2006a, p.7). This is presented as a 'rule of thumb', though no empirical support for this exhortation is cited. The focus of the guides is on the information the board requires, with the underlying assumption that if the board has the right information then it follows that it will be effective. There is little consideration of how board dynamics might affect the board's performance of its role, nor how the role might change in response to external circumstances.

Governing the NHS (NHS Appointments Commission and DH, 2003) was revised and reissued in 2010 as *The Healthy NHS Board: Principles for Good Governance* (National Leadership Council, 2010). This had more emphasis on the responsibility of the board to ensure the quality and safety of health services, the accessibility and responsiveness of the services, plus accountability for public funds. The role of the board is described as to formulate strategy, ensure accountability and shape culture. Within the board the NED role is described predominantly as one of challenge – to strategy

development and to ensure accountability, though also contributing external perspective and skills.

As will be explored further in the next chapter, the recommendations for the board on how it should allocate its time proved to be difficult to meet in practice. Many NHS boards allowed financial and performance issues to dominate, to the detriment of strategic direction and the attention given to the quality of care provided (Williamson, 2008). This flags up the challenge of how private sector corporate governance mechanisms incorporated into the public sector may need to adapt to meet a different set of requirements. It also raises the question of the utility of the ideological mantra that the private sector is more effectively governed than the public sector. Private sector models of governance have proved problematic, for example, in the banking sector. Indeed, there may be some learning here for the private sector from the public sector in terms of good governance, particularly in the area of risk management and firmer regulation.

Section summary

This section has shown that governance expectations of the NED role swiftly changed after the creation of PCTs from a more representative role to one mirroring aspects of the role in the private sector, following the Higgs (2003) report. However, while some aspects of governance were similar to the private sector, such as a unitary board and subcommittees such as the audit committee, there were also differences. These included the presence of the professional executive committee and also clinicians on the board. Much of the guidance for NHS NEDs and Chairs was based on private sector practice and, sometimes prescriptive in content, emphasised the board's role in monitor performance, strategy and safeguarding values.

1.3 Changing Government expectations: 2005

Further Government reforms to the NHS included an increasing emphasis on the role of commissioners to bring about improvements to health services. The White Paper *Creating a Patient-led NHS: Delivering the NHS Improvement plan*

(DH, 2005) brought about major changes to PCTs. It emphasised their primary function was to improve the health of its local population by commissioning comprehensive and equitable high-quality health services, which delivered value for money. Providing community services was seen as a distraction from its primary commissioning role and PCTs were instructed to stop providing these and to become solely commissioners (Crisp, 2005).

The number of PCTs was halved to 151 with the expectation that these larger PCTs would be better able to negotiate as commissioners with the large hospitals. The merging of PCTs also moved many of them to being coterminous with county or unitary councils, though this did lead to wide variation in the size of the populations they covered, from fewer than 100,000 to more than one million people (Baird, 2010). One of the expectations of this change was that there would be closer joint working with the local authorities. GPs were also to become increasingly involved in commissioning, with PCTs required to ensure all GP practices in their areas were involved in practice-based commissioning.

The boards of these new PCTs were expected to be more business-like than before, with an emphasis on financial control and the ability to act as effective commissioners. While reiterating that PCTs were to be local organisations, expected to work closely with local GPs and the local health authority to assess local needs and commission locally-appropriate services, there was also increased centralised control, with the need for PCTs to meet a range of centrally- and locally-set targets, which would be assessed by the national regulator, the Healthcare Commission.

The requirement to be locally responsive, yet comply with national policy directives, was reinforced by the World Class Commissioning programme (DH, 2007), introduced in 2007 and designed to improve PCTs' ability to commission services and improve health outcomes for their populations.

There were various calls for PCTs to be able to be subject to less centralised control and have greater freedoms, such as lighter-touch performance management and the ability to manage their budgets over multiple years (Kings Fund, 2008). This was considered as a possible outcome of the World Class

Commissioning Programme, with greater freedoms for those PCTs judged as being high performing.

While the role of performance targets has been criticised (Bevan and Hood, 2006), a report by the Nuffield Trust (Connolly *et al*., 2011) considered the strength of the target regime in England to have driven faster reductions in waiting times for patients in England than in Scotland, Wales or Northern Ireland (p.7).

All PCT NEDs were required to reapply for their position in 2006/07 if they wished to continue serving on the PCT. Prospective NEDs wishing to apply for positions were required to have significant experience in areas such as finance and governance or specific expertise relevant to the work of the PCT. Local knowledge was not a criterion, though preference was to be given to candidates who lived in the area served by the PCT (Appointments Commission, 2006). The roles for NEDs are in Appendix A, p.293. Of note is the fifth bullet point: 'Accept accountability to the Strategic Health Authority for the delivery of the PCT's objectives and ensure that the board acts in the best interests of its local community.' The guidance does not seem to anticipate any tensions between accountability to the SHA and acting in the best interest of the local community.

All PCT Chairs also had to reapply for their post in the 2006-07 reorganisation. The interview process included an assessment of seven key competencies, the first five derived from the NHS Leadership Qualities Framework: Self-belief and drive; intellectual flexibility; holding to account; team working; effective influencing and communication (NHS Institute for Innovation and Improvement, 2006).

Two additional competencies were added that were identified as particularly relevant for the role of the Chair of a PCT: Patient and community focus, and the ability to provide strategic direction. Candidates were expected to bring a significant portfolio of business skills as well as experience of building alliances with a range of stakeholders (Alban-Metcalfe *et al.,* 2010).

The inclusion of competencies from the NHS Leadership Qualities Framework signal a significant leadership role over and above that required of NEDs. The inclusion of experience in alliance building and the requirement to have a high level of commitment to patients, carers and community also go beyond the organisational focus of NEDs' roles and responsibilities.

The recognition of PCTs as local leaders, responsible for a large proportion of the NHS budget, gave further weight to calls for their greater local democratic accountability, with the Prime Minister promising in a speech on the NHS that ways to achieve this would be explored (Brown, 2008).

A desire for greater stakeholder accountability and greater citizen responsiveness within the NHS (DH, 2001) had led, in part, to a new organisational governance form introduced for hospitals, NHS Foundation Trusts. These hospitals had to pass certain requirements to gain greater financial freedoms, and were set up as public benefit organisations. The first NHS Foundation Trust came into being in 2004 and in addition to the board of directors, with both NEDs and executive directors, had a Board (later to be called Council) of Governors, with representatives from various stakeholders such as staff groups, commissioners and local authorities. Members of the public could apply to become members of the Trust and directly elect some of the Governors, to represent patient or community interests. One of the key roles of the Board of Governors is to hold the board of directors to account on behalf of local people, with powers including the ability to appoint or remove the Chair and NEDs and to approve the appointment of the CEO (National Health Service Act, 2006, S7 (17)).

The accountability of PCT boards, who held a large percentage of the NHS budget and who commissioned care from the NHS Foundation Trusts, remained an outstanding area of concern.

The NHS Confederation (2007), in a consultation with its members entitled *PCT accountability and the democratic deficit*, put forward several potential options for improving accountability, including an option for a model of governance based on the Foundation Trust model, direct elections to all or part of the non-

executive body and allowing local government scrutiny of appointment of PCT Chairs. The latter suggestion was taken forward, with the Appointments Commission tasked with exploring ways to strengthen local involvement in the recruitment and selection for NHS Public Appointments (Appointments Commission, 2009). The project was terminated following the announcement of the abolition of PCTs and the Appointments Commission.

Section summary

This section shows how the Government's expectations of PCT governance and accountability changed over the lifetime of PCTs. The guidance for PCTs at their inception sees them as part of a move to greater localism and, for Chairs and NEDs, being part of the local community and representing its interests was an important part of their role in 2002.

However, the capabilities of PCTs to drive through Government reforms and increase efficiency and effectiveness was questioned, leading to a reduction in their number in 2006 and the introduction of the World Class Commissioning development programme. This resulted in changes to the NED role, with an increasing emphasis on corporate governance practices from the private sector. The business and financial skills required for PCT boards led to an emphasis in recruitment for NEDs with appropriate business skills.

While the focus on the board's role in ensuring efficient organisational performance was one influence on the role of the NED, other policy streams influenced governance in PCTs, including increasing expectations of the involvement of local people and patients at every level of health service organisation and the democratic accountability of PCT boards. Tensions remained for PCT boards between sometimes conflicting Government expectations of national and local accountability (Newman, 2001), which is an area of interest for this study.

1.4 Governance changes following announcement of abolition of PCTs

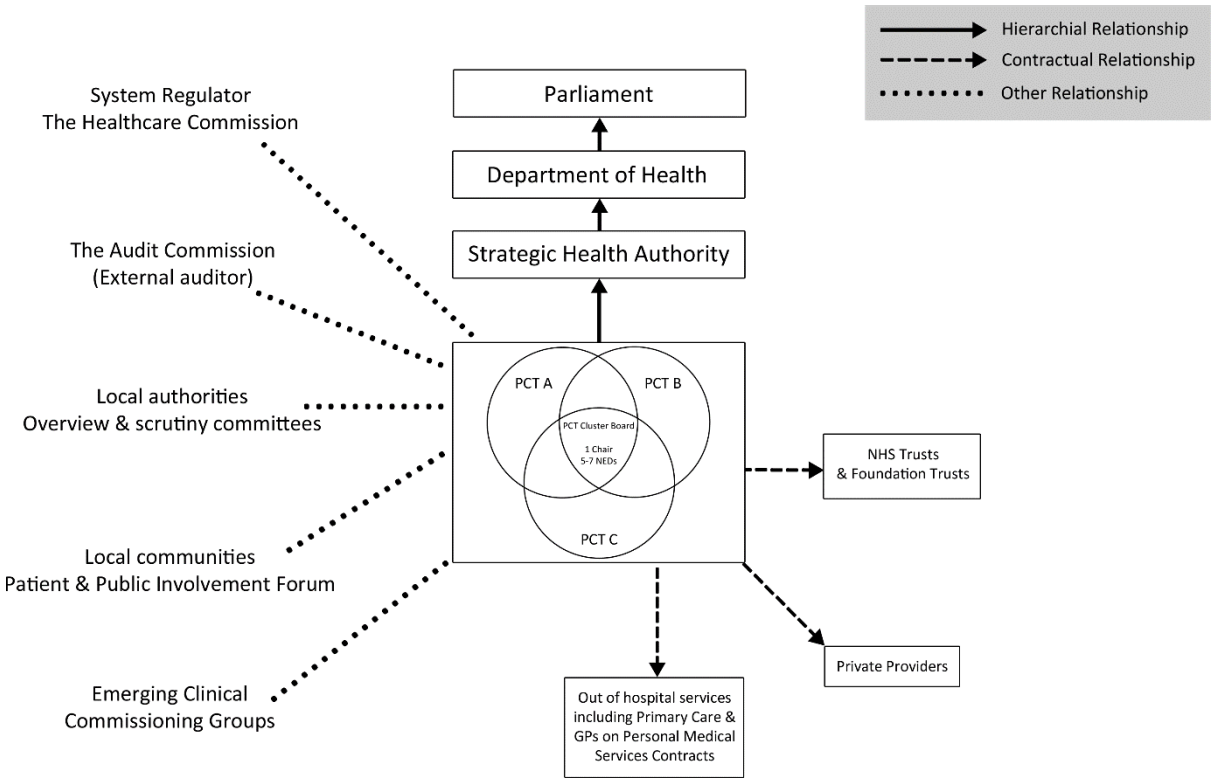
Following the 2010 General Election the new Coalition Government set out its plans for the NHS. The White Paper *'Equity and Excellence: Liberating the NHS'* (DH, 2010a) announced that commissioning of healthcare would be transferred to Clinical Commissioning Groups (CCGs) consisting of a majority of GPs. The ambition was similar to that of nine years earlier, when PCTs were created, for healthcare 'run from the bottom up, with ownership and decision making in the hands of professionals and patients' (DH, 2010a, p.1). Functions such as public health were to transfer to local authorities and specialised commissioning to a new National Commissioning Board (later to be called NHS England). There was no longer seen to be a role for PCTs, which were to be abolished. This came as a surprise to many within the NHS. It had not featured in the political parties' manifestos, although the Conservative Party had announced its intention for increased clinical involvement in commissioning.

Following this announcement, in a bid to reduce management costs during a time of transition to the new system, PCTs were told to share management functions and to work as 'clusters' (DH, 2010b). These clusters were to help develop the new system whilst maintaining oversight and delivery of performance. Guidance from the Department of Health in July 2011 announced that there would be 51 clusters of PCTs, although the 151 PCTs would remain the statutory bodies (DH, 2011a). The number of PCTs working in a cluster varied from two to ten. At that time, governance structures for the cluster PCTs were not prescribed. However, in September 2011 clusters were directed to have a similar governance structure, with one cluster board operating as a joint board of the different constituent PCTs and with a joint management team. Changes were made to regulations to enable Chairs and NEDs to serve on the board of more than one PCT (DH, 2011b), so that on the cluster board they acted as a NED of more than one of the constituent PCTs, with one Chair of the PCT cluster. As there were far fewer places for NEDs on the cluster boards than when each PCT was operating singly, many NEDs were not appointed to

the cluster board. Schemes of delegation were put in place setting out the functions the cluster board exercised on behalf of each constituent PCT.

The cluster board was still required to have statutory committees, such as the audit committee, and had the same accountabilities although a new relationship was with the emerging CCGs. By this stage, PCTs no longer directly provided community services and these revised arrangements are shown in figure 1.3, with an example of three PCT boards in a cluster arrangement.

Figure 1.3: PCT cluster board arrangements and accountabilities



The interviews for this research took place between October 2011 and April 2012. By this stage, many PCTs had clustered across a geographical area and were working together with one management team. Other PCTs were in the process of clustering, while some remained a single PCT. CCGs were in the process of being formed, with the intention that there would be a period of transition of functions until the PCTs were abolished in 2013. Some of the support functions for CCGs were to be provided by Commissioning Support Units and these were being set up. In this time of transition, however, the PCT

retained statutory responsibility for its existing functions, such as public health and commissioning.

This means that the interviews reflect a time of great change and uncertainty in PCTs. Many NEDs interviewed had either recently moved to cluster boards or were in the process of doing so. The time of transition brought about changes in the NED roles and also anxiety about the future. It influenced the design of the research, assisting in the recruitment of NEDs, as many were keen to have their story told before PCTs were abolished, but made access to other possible informants, such as executive directors, difficult as organisational forms rapidly changed and new ones emerged.

The CCGs took on the commissioning role from PCTs in April 2013, though other functions were transferred to other bodies, such as the public health function to local authorities. The governing body of the CCG does not have non-executive directors though it does have two lay members, one of whom has particular responsibility for corporate governance and audit. The other has particular responsibility for representing the patient and public voice.

Section summary

This section has described some of the changes brought about by the coalition government in 2010 that had a direct impact on PCTs, including the transitional arrangements put in place before their abolition in 2013 along with organisations such as SHAs. These are important considerations as they set the context for when this study was carried out, and the direct impact these changes had on the PCT NED and Chair role.

This chapter has given an overview of the changing policy context within which PCTs operated. This is important both when considering the ability of the PCT board to exercise local autonomy and also how governance practices might need to adapt within a public sector context. NEDs and Chairs in the public sector face shifting policy requirements as well as having to work within complex accountability arrangements, different to those faced by their counterparts in the private sector.

In this next section, I outline the structure of my thesis and the content of each chapter.

1.5 Overview of thesis

This thesis is made up of eight chapters. This first chapter has provided some of the general context for this study, describing the creation, function and then abolition of PCTs, as well as the expectations of the NEDs and Chairs.

Chapter Two is the empirical review, consisting of three sections. The first section examines the introduction of corporate governance into the NHS and the influence of New Public Management (NPM) and post-NPM approaches, often referred to as public governance. The second section examines research and theories from private sector practice to identify how the NED and Chair role is conceptualised. One stream of research considers the processes of governing and a behavioural approach to studying boards, with particular reference to aspects of power and the ability of NED to contribute. Issues of power are highlighted as an area of interest for this study, along with how the salience or strength of association with different identities may influence the role.

The third section presents a critical appraisal of the literature on boards within the NHS, with particular emphasis on the role of NEDs and Chairs. The lack of a developed theoretical approach emphasises the need for an examination of how the practice of corporate governance might be different in the public sector, which is proposed to be examined using the example of the PCT NED and Chair role and two subsidiary research questions. The chapter concludes by identifying particular concepts of interest that may influence the PCT NED and Chair role and contribution, namely the influence of identities on role, a consideration of power relationships that may enable or hinder contribution and, finally, the influence of the wider context, looking particularly at how different models of governance may influence the role of the PCT board and its members.

Chapter Three then turns to the methodological approach to the study and its underpinning philosophical perspective. The first section sets out why a qualitative approach was felt appropriate for this study and explains the critical realist approach. The second section discusses the research methods chosen, semi-structured interviews, with the third section detailing the approach to sampling and recruitment, ethical issues and the interview process. The fourth section outlines the approach to the analysis undertaken by the current study, based on Braun and Clarke's (2006, 2013) methodological approach. The final section includes a reflexive account of my approach, being an insider-researcher and addresses the issue of quality assurance.

Chapter Four is the first of four chapters examining the results of the research. The first section presents different NED understandings of their role and finds a dominant theme to be a conformance-oriented role involving the scrutiny and challenge of organisational performance. The second section examines different influences on the role, such as professional background and other NED roles. The third section considers how different social identities influences behaviours and understandings of the role. Within the board, NEDs saw themselves as a distinct group to the executive and there was a strong identification with a public service identity and with stakeholders, whether the local community or broader public. This had a strong influence on NED behaviours with a role in promoting and defending the public interest, a different conceptualisation of the role to that within the private sector.

Chapter Five examines power and contribution within the PCT. Sources of power for NEDs included the credibility and authority drawn from the possession of valued skills and expertise and also derived from chairing key committees. When it came to using power to achieve results in line with their interests, NEDs used methods of influence rather than more coercive forms of power. Analysis of examples of contribution showed conformance-oriented examples dominated. However, NEDs also contributed to a range of other performance-oriented roles, working collaboratively with executives and contributing knowledge and skills. This sometimes saw them step into more

operational roles, but without causing apparent conflict for NEDs between this and their monitoring role.

Chapter Six considers the dynamic nature of the NED role. Power is relational and this chapter considers how PCT NEDs were able to exercise influence on the PCT board, particularly in the context of wider relationships such as the hierarchical one with the SHA, contractual relationships with primary care practitioners and commissioning relationships with hospitals. While existing NHS governance studies have found the NED role to lack power, this chapter explores the circumstances where NEDs did and could exercise power, such as challenging the SHA and professional power to defend patient interests. However, in other situations NED power appeared limited, unable to challenge managerial hegemony in matters such as control of the PCT's expenditure in light of SHA demands. This chapter also shows how the NED role in the NHS evolved as the policy context and societal expectations of the public sector board changed. This saw NEDs take on new roles in monitoring the quality of services and, during the transition of functions to CCGs, holding the organisational memory and taking on an educational role.

Chapter Seven turns to the role of the PCT Chair and considers in more detail aspects of the leadership role. As leader of the PCT board, the Chair played a key role in determining the boundaries of the NED role and in creating the right environment for them to have influence. For some Chairs the role of the NED was viewed predominantly as one that brought skills and knowledge to improve the efficiency of the PCT, with an emphasis on their independence and role as external scrutineer. Other Chairs encouraged close collaboration between NEDs and executives in more performance-oriented roles. The PCT Chair also had a leadership role in the local health economy, but the extent of this role varied. For some, the dominant emphasis was the efficiency of the organisation, reflecting a new public management approach. Other Chairs were more oriented towards a more networked approach, seeking collaboration with other stakeholders and reflecting elements of public governance.

Chapter Eight brings together the findings of this research and considers them in light of the research questions and existing research and theory. In

considering the NED role, a model is developed to show different types of NED within PCTs. These different types of NEDs, influenced by personal background and the salience of different identities, drew on different sources of power and their key areas of contribution varied. The policy context was another influence on the role and the chapter examines how different models of governance (Newman, 2001) exerted influence on the PCT board and the type of NED behaviour required. The chapter concludes by drawing together the different conceptual frameworks used to suggest that, rather than a uniform role, the NED and Chair role varied in response to personal cognitive factors and an external policy environment that was sometimes conflicted as to the type of governance model the PCT should be operating towards. Previous studies on NHS governance have found the NED role to lack clarity (Veronesi and Keasey, 2010; Storey *et al*., 2010). A contribution of this study is the drawing together of different conceptual frameworks to understand why this might be. It demonstrates ways in which the NED and Chair roles could have different emphases than found in the private sector.

The chapter concludes with some critical reflections on the research process and the limitations of the study before considering the implications of this study for further study and practice.

Chapter Two: Literature review

When considering the areas of interest for this study, namely the adoption of private sector corporate governance practices of boards and NEDs into the NHS and the tensions for these boards between acting in the local interest when also required to meet national policy directives, three areas of literature are arguably most substantively relevant.

The first is to consider the introduction of corporate governance mechanisms into the NHS and how this model of governance has been influenced by what might be seen as different waves of reform in the public sector, that is, New Public Management (NPM) and then what has been termed post-NPM or public governance. Such terms are contested and it is not the purpose of this review to analyse NPM in depth but to consider its practical impact upon corporate governance in the NHS.

Second, in determining what might be different about the conceptualisation of corporate governance in the public sector it is necessary to first identify how this is understood in the private sector. The role of the board – and particularly the role of the NEDs and their contribution to governance – is explored in the second section.

The third section turns to corporate governance within the public sector in general and the NHS in particular. The gap in our present knowledge, the contribution of this present study and two subsidiary research questions are then introduced which concentrate on the role and contribution of PCT NEDs and Chairs as a means of exploring the broader questions identified.

The chapter concludes with a conceptual framework that is used in this research.

2.1 Governance and the public sector: changing influences

This first section examines the introduction of private sector corporate governance practices into the NHS as part of the reforms to improve the efficiency in the delivery of public services, often referred to as New Public Management (NPM).

Some have persuasively argued that NPM encompasses concepts such as performance measurement, a focus on managerial rather than professional power, and private sector-style management practices with a focus on improved efficiency and effectiveness (Hood, 1991). However, NPM is a contested term that may be understood and defined in different ways, with Greener (2009, p.60) arguing that Hood's work represents what may be considered an early ideal type of NPM. For others, NPM is seen as developing from a managerial focus on public services to later being associated with the use of markets to reform the delivery of public services (Osborne and Strokosch, 2013).

While some scholars argue against NPM being considered a new approach to management (Gray and Jenkins, 1995) and others propose different variants and models of NPM (Ferlie *et al*., 1996), there is more general agreement on the tenets NPM encompasses, such as the efficient and effective use of resources, managerial accountability, the decentralisation of management within public services to autonomous organisations, and the increasing use of markets and competition within the public sector (Pollitt, 2002; Rutgers and Van der Meer, 2010). Of relevance for this study is how NPM has influenced the NHS and particularly its organisational governance.

Following the Griffiths report (Griffiths, 1983) NPM practices were introduced into the NHS, with the creation of NHS Trust boards in 1992. Trusts were to be financially self-sufficient and run as businesses, managing resources and contracts. This focus on organisational efficiency and on the individual hospital as a unit was felt by many to be at the expense of wider health-system efficiency (Mueller *et al.,* 2003). The replacement of elected members to health

authority boards by appointed NEDs was also considered to weaken local accountability (Ferlie *et al.,* 1996). However, the major policy drive was for the hospital and health authority boards to be focused on internal control to improve the efficiency of organisational operations. NEDs were recruited from the private sector with the expectation that they would help bring about a transformation in how the hospitals were run, with an increased emphasis on value for money for the taxpayer, with a seeming preference given to those with business backgrounds (Ashburner, 2003).

Policies of New Labour

When New Labour came to power in 1997, the initial emphasis on localism, collaboration and partnership led to some suggestions that New Labour had rejected the NPM of its predecessors and introduced post-NPM, with less emphasis on top-down management and market accountability and more on networks and devolved decision-making power closer to the final user/citizen (Addicott, 2008; Veronesi and Keasey, 2011). However, rather than rejecting the principles of NPM, its key concepts of increasing the efficiency and quality of public services were driven forward by Labour, with performance indicators and central targets to be achieved by NHS Trusts introduced. These are seen by Exworthy *et al*. (2003) as central to NPM as they can be used from afar by managers to measure the effectiveness of clinical as well as organisational performance.

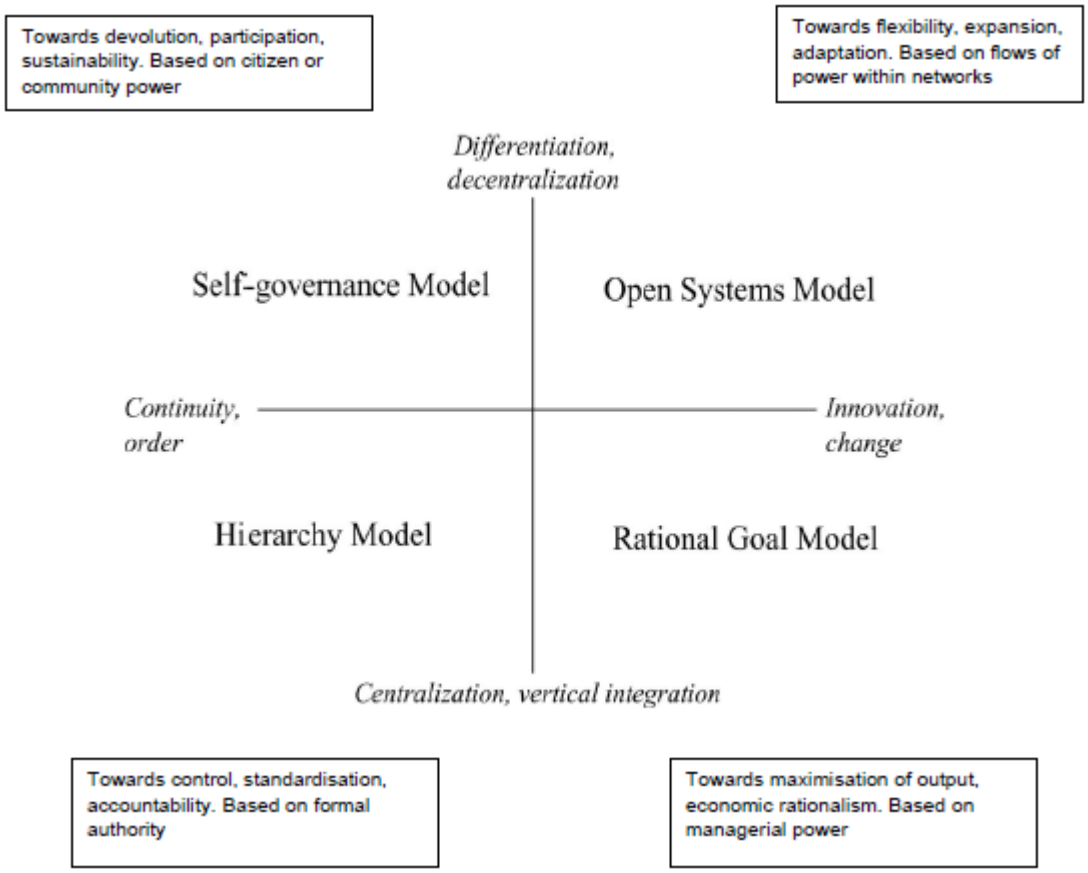
The influence of these NPM practices emphasised the role of the NHS board in ensuring the organisation met its performance targets, with a focus on increasing the efficiency and quality of public services. The strong pressure put on NHS boards and their organisations to meet centrally-set targets meant that this period was dubbed by Bevan and Hood (2006) as a ‘targets-and-terror regime’ (p. 533). The failure of Trusts to meet performance targets could result in the removal of the Chair and Chief Executive (Kings Fund, 2008).

This strong centralised control was accompanied by a move to decentralise the provision of services, with the role of government seen as shifting from the

running of public services to setting the goals for organisations, such as NHS Trusts, and then holding them to account through performance management (Klijn, 2008). However, the policy context for organisations such as PCTs was not that straightforward. They had been set up as local organisations, with expectations that they would forge partnerships with local communities to shape how services could be commissioned and provided. This was at odds with the central target-setting and performance management model.

These tensions in governance are captured by Newman (2001) in her dynamic model of governance under the New Labour government. She identifies four different models of governance – the hierarchy, self-governance, open systems and rational goal model – which are plotted against two axes representing the degree of centralisation/vertical integration or decentralisation/differentiation, and an axis ranging from continuity and order to innovation and change. Each model exerts a pull that exerts pressure on the other models, which are described as the dynamics of change (figure 2.1).

Figure 2.1: The dynamics of change (Newman, 2001, p.38)



The hierarchy model, strong on continuity, order and centralisation is suggested by Newman to typify the NHS prior to the 1980s. The rational goal model is also seen as strong on centralised control (such as centrally-set targets) and to also embrace innovation and change, which could be equated with markets and NPM, while the self-governance model, with greater decentralisation, emphasises partnership with citizens and co-production. This has similarities with what may be called post-NPM approaches. The open systems model is also decentralised but embraces innovation and new ways of working, what are described as ‘cross-cutting initiatives’ and the development of networks.

Network theory proposes that modern-day life consists of numerous networks of people and organisations that cut across state and civil boundaries, the public and private sector and, indeed, across country boundaries. These networks of organisations exchange resources and negotiate shared purposes with significant autonomy from the state, ‘with no sovereign actor able to steer or regulate’ (Rhodes, 1997, p.57).

The model by Newman is a dynamic one, and, rather than organisations sitting in any one quadrant, different approaches exert different 'pulls' on organisations. Newman (2001) sees the mix of approaches utilised by Government as producing significant tensions for public sector organisations. So, for example, the New Labour Government put in place policies and initiatives for community development approaches to enable the public to be involved in public service strategy and decision making, suggesting an emphasis on the self-governance or open systems model. Traces of this can be seen in the Sure Start programme, set up to address the social and health needs of families with young children. However, the Government also put in place the requirement for organisations to meet short-term targets, which were not compatible with the longer timeframes needed to develop inclusive and flexible approaches to engaging citizens.

The dominant pull in the first Labour term of office is argued by Newman (2001, p.165) as being towards vertical integration, with the tightening of central control strongest in the mainstream professional services, such as health, where use of the markets was accompanied by strategies to regulate professionals, such as the introduction of clinical governance mechanisms. While health policy might seem to fit predominantly within the rational goal model, it also includes elements of the open system and self-governance models, linked with needs for partnership, networks and new forms of public participation.

However, a later co-authored study by Newman (Newman *et al.,* 2004) found the practices of NPM and its emphasis on performance and targets dominated the public sector under Labour rather than the 'pull' towards more collaborative governance. There were conflicting imperatives for local actors to both encourage participation but also to deliver on the targets imposed from above, even if these were in conflict with local views. The authors makes the point that new forms of governance do not displace existing forms 'but interact with them, often uncomfortably' (Newman *et al.,* 2004, p. 218). The model by Newman is considered further by Andresani and Ferlie (2006) in the light of ethical theories, who find it helpful in its recognition of the self-governance model as an addition to the usual networks, markets and hierarchy considerations. They also highlight the findings of many scholars of the apparent contradictions between

increased marketisation and managerialisation, with centralised control exercised through performance measures.

PCTs, as already discussed, were at this interface of being local organisations, expected to work within networks with others and in a regulated market, yet also to operate within a hierarchical system that could cause tensions for their boards. At their inception Klein (2003) questioned whether PCTs would have the freedom to determine their own priorities, within a centrally-funded system and the Treasury requiring evidence of an effective use of resources (p.196).

This sceptical view was confirmed by later empirical studies. In a comparative case study of PCTs by Dowling *et al.* (2008), the hierarchical accountability of PCTs to the Department of Health was found to be a much stronger control than other accountabilities, such as to local communities. A later case study of Department of Health and SHA directors that took place between 2007 and 2009 found the imperatives of delivering central priorities meant that, in practice, the Department of Health maintained control rather than this being devolved outwards. Clear performance management ran from the NHS Chief Executive to SHA Chief Executive and then out to Trust Chief Executives to ensure delivery of central targets (Storey, 2011).

A wider-reaching case study of two local health economies, including PCTs, between 2006 and 2009 (Exworthy *et al.,* 2010), found that while health policies had allowed greater local autonomy over input and process, there was also greater centralisation through regulation and performance management of outcomes. The decision space available to PCTs was also reduced by policies such as the introduction of NHS Foundation Trusts, patient choice and Payment by Results (p.179). However, Exworthy *et al.* (2010) found an unwillingness to exercise the local autonomy that *was* available, due to factors such as risk-averse behaviours, in the light of threatened sanctions if performance indicators were not met (p.171). The power of the PCT board to innovate locally was constrained, in part due to the performance management system and the strong hierarchical control of the Department of Health.

Interestingly, the World Class Commissioning programme (2007), with its aspiration of first-class commissioning by PCTs leading to better health outcomes and reduced health inequalities was found by McCafferty *et al.* (2012) to exhibit similar tensions. The assessment process, performance management regime and short timeframes required by Government hindered the longer-term organisational cultural change and relationship building required to meet the programme's overall aims

This hierarchical accountability throws into question the role of the PCT board and its ability to lead, direct and control the organisation, suggesting that the practice of corporate governance might be different within the public sector where there are different accountabilities.

The relevance of other private sector practices for the public sector has been questioned, such as the difficulties in measuring performance in the public sector and the need for public sector organisations to co-operate vertically and horizontally with others (Pollitt, 2002; Hood, 2005). This is developed further in the new public governance approach of Osborne (2006).

Post-NPM approaches and public governance

One of the limitations of NPM identified by Osborne (2006) is that its intra-organisational focus is limited within a pluralist state, where there are both multiple policymaking processes and multiple actors involved in the delivery of public services. He proposes that new public governance, which has its roots in network theory, can better reflect this plurality. Its focus is on 'interorganisational relationships and the governance of processes, and it stresses service effectiveness and outcomes' (Osborne, 2006, p. 384). In a later paper, Osborne and Strokosch (2013) identify a further limitation with NPM approaches, that its origins in product manufacturing make it ill-suited to public service delivery. The delivery of services is considered as distinctly different to the consumption of manufactured goods because the production and consumption of services are inseparable. This, Osborne and Strokosch (2013) suggest, means a recasting of the public sector service user away from the

concept of consumer as articulated by NPM to one as a co-producer of services (p.S38). In other words, patients are people not products.

While there are other post-NPM approaches, as well as the new public governance (in later papers referred to as just public governance), espoused by Osborne (2006), such as public value-management (Stoker, 2006) and new public service (Bozeman, 2007), a review by De Waele *et al*. (2015) found similar characteristics across all post-NPM approaches, such as the need for cross-sector collaboration, networked governance and public value.

The idea of public value is one that has gained increasing attention in recent years. The public value framework was originally created by Moore (1995) to consider how value might be increased in the public sector, not only in financial terms, as in the private sector, but also to include other benefits valued by citizens. Jorgensen and Bozeman (2007) in a review of the literature found 72 public values they categorised to seven different constellations. These include the public sector's contribution to society, such as to the common good and social cohesion, and the relationship between public administration and the citizen, including areas such as legality, equity, dialogue and user orientation (p.360-361).

Many of these aspects of public value were reflected in a Government paper (Prime Ministers Strategy Unit, 2007), which set out a vision of public services as self-improving institutions, responsive to needs and preferences of local citizens. In response, Williams *et al.* (2007) in an opinion paper, consider some of the challenges for PCTs in ensuring public value, which they define as 'the distinctive contribution that public sector services make (or should make) to society' (p.4). The paper calls for a more active dialogue by the PCT with the local community to define what this contribution should be, both reflecting and shaping values and aspirations. The authors consider that PCTs are little-known by most of the public, with little public engagement and the Patient Forums having limited impact. With regards to the corporate board model of governance, they note that NEDs have so far failed to generate 'the degree of public "voice" envisaged' (p.5).

The paper by Williams *et al.* (2007) highlights some of the different expectations of boards within the public sector as opposed to the private sector. The NPM model, imported from the private sector, focuses on interorganisational efficiency, but within the public sector there are broader expectations of a contribution to society. The expectations of the NED role are also different. Of interest for this present study is how PCT NEDs might have exhibited this public voice, or indeed if this was how the NEDs understood the role.

As noted in Chapter One, there remained a tension between local political and community expectations of a local representative on the board representing their interests and a governmental expectation of a NED role similar to that within the private sector, acting corporately with the rest of the board to fulfil duties in monitoring performance and providing strategic direction.

Section summary

This section has considered how corporate governance is conceptualised in the public sector. The import of NPM practices into the NHS led to the development of boards modelled on the private sector and the creation of NED posts.

These boards embody the key dimensions of corporate governance, which are often connected to the characteristics of NPM. They were expected to improve the efficiency and effectiveness of the individual organisation, with an emphasis on NEDs bringing in private sector experience. This emphasis was increased with the creation of the restructured PCTs from 2006.

While healthcare boards have NPM elements, they also have additional elements, which have been highlighted in the recent trends in governance often referred to as public governance. These call for a greater consideration of public value, interorganisational collaboration and citizen responsiveness.

These developments meant that the landscape for healthcare boards such as PCTs was complex, with different governance types at play that could lead to tensions and conflicts (Newman, 2001). This section has shown that the strong

performance management system under Labour is considered to have curtailed the ability for PCTs to act in ways that are more locally responsive.

The role description for PCT NEDs emphasised the organisational focus of the board and the corporate nature of the NED role, reflecting corporate governance practice from the private sector. However, there were also expectations of PCT NEDs acting as a 'public voice' and representing a public interest. How these tensions and conflicting expectations influenced the understanding of individual NEDs and Chairs of their role within the governance of PCTs is not fully understood and this study aims to provide insights into this area. This will help identity not only if the practice of corporate governance is different within the public sector but also how the NED role may be influential in bringing a public voice to decision making.

Having considered the broader context within which PCTs operated, the following sections consider organisational governance and approaches to understanding both the board's role and the NED role, first within the private sector, then the public sector and the NHS.

2.2 Corporate governance within the private sector

While there are differing definitions of corporate governance, the simplest is that it concerns the systems by which companies are controlled and directed (Committee on the Financial Aspects of Corporate Governance, 1992). As Tricker (2015, p. 45) puts it, 'management runs the business; the board ensures that it is being well run and run in the right direction'.

The majority of boards in the private sector in the UK are unitary boards consisting of both executive and independent or non-executive directors. The proportion of non-executive directors has increased since the Cadbury report (Committee on the Financial Aspects of Corporate Governance, 1992) and boards may now be predominantly non-executive, with the only executives

being the CEO and chief finance officer. This change in practice is important, as many older studies on the role of the NED took place when the NEDs were in the minority rather than the majority.

One stream of literature looks at board roles created by individual directors, based on different corporate governance theories, and will be examined first.

Theoretical approaches to the role of the NED

Agency theory has been the dominant approach within the mainstream law and economics literature on corporate governance.

The separation of ownership of the company (by shareholders) from control (by senior managers) has led to a focus in corporate governance literature on the principal agent relationship and in particular the ‘agency problem' – how to prevent the agent (senior manager) from working in his or her own self-interest rather than that of the owner, the shareholder (Jensen and Meckling, 1976; Eisenhardt, 1989).

Mechanisms introduced to address this include an effectively-structured board with independent (or non-executive) directors; contracts that encourage shareholder orientation (such as bonuses related to profits) and the stock market, which is theorised to be an effective ‘market for corporate control’ (Clarke, 2004, p.5). The latter comes into play when the firm’s internal governance fails and underperformance or valuation makes it an attractive takeover target. This study concentrates on the role of the board, rather than these other elements.

The independent director, or NED, on the board is seen as having a primary role in the monitoring of management to ensure self-interest is kept in check (Daily *et al.,* 2003). The presence on the board of a greater number of external directors would therefore be expected to lead to increased performance. Many, however, have challenged this assumption. In an overview of the corporate governance debate to date, Daily *et al.* (2003) found little evidence to support a

link between board independence, as indicated by the independent directors, and board performance, with financial performance used as a proxy for board effectiveness. The need to go beyond agency theory, with its limited view of the board as a monitor of senior management, is one supported by many scholars (Daily *et al*., 2003; Gabrielsson and Huse, 2004; Huse *et al.,* 2011).

Organisational theories are less developed but suggest a range of different roles for the board and the independent director.

Stewardship theory has its roots in psychology and sociology and, in contrast to agency theory, sees that agents can act as stewards, motivated to act for the collective good for the organisation (Davis *et al.*, 1997). Agency theory focuses on extrinsic motivation, whereas stewardship theory focuses on intrinsic motivation, such as the potential of self-actualisation. The principal and manager can choose whether to have an agency or a stewardship relationship, a decision that will be dependent on the level of risk acceptable to each individual and the willingness to trust the other party (Davis *et al.*, 1997). With an emphasis on the agency relationship potential costs are minimised, but the opportunities for maximising potential performance comes from a stewardship relationship. Where there is a participative, empowered management culture, NEDs and managers are more likely to have a principal-steward relationship. The contribution of the NED is to work alongside managers, working collaboratively to add value (Davis *et al.*, 1997, p.39-40).

A later theoretical paper (Sundamurthy and Lewis, 2003) considers the benefits to organisations of both control and collaboration being held in tension, leading to constructive challenge and higher performance, though it warns that an overemphasis on either can be detrimental, leading to distrust amongst group members or ‘group think’, where there is a reluctance to raise challenging views.

Both agency and stewardship theory concerns the role of the NED within the board and the relationship with managers. Managerial hegemony theory also considers internal relationships but considers that the full-time professional

manager, with his or her superior access to information and how this is shared with part-time NEDs, effectively controls the board, limiting the NED role to little more than ‘rubber-stamping’ executive decisions. This was the view of Mace (1971) on his studies of companies in the United States, although this was at a time when powerful CEOs controlled the board and was before the rise of the more independent boards following high-profile corporate failures. A similarly influential work in the United States by Lorsch and MacIver (1989) also considered the power of the NED to be limited compared to the CEO, who can control the agenda and information provided. While they may have legal authority, Lorsch and MacIver (1989) considered NEDs only to have power if able to act collectively, which circumstances such as a lack of group cohesiveness and time may prevent. However, this view has been challenged by more recent studies that examine the power part-time directors have been able to exercise, and which will be considered further when considering behavioural approaches to the board role.

The assumption that corporations should be run for the benefits of shareholders is challenged in stakeholder theory. Rather, Blair (2004), a key proponent of this view, argues that organisations are bundles of assets needing to be governed by arrangements to benefit all who contribute to those assets, not only shareholders but also long-term employees, investors, suppliers and others who have contributed firm-specific assets. By incorporating different stakeholders on boards it is suggested as being more likely that organisations will respond to broader interests in society than just the shareholders (Blair, 2004). The involvement of stakeholders and the negotiation of interests they represent may lead to a more complex set of objectives that meet the needs of wider stakeholders. Stakeholder theory can fit with both agency and stewardship theories in terms of how board roles are enacted to ensure those objectives are met.

The board also has a role in how the organisation responds to its external environment, helping the organisation to recognise and manage external pressure. Resource dependency theory (Pfeffer and Salancik, 1978) considers organisations as interdependent with their environment. A key function of the

board is therefore to enable the organisation to respond to the external environment and minimise dependencies, so that it is able to leverage influence and resources. NEDs are selected with appropriate skills and knowledge, as well as external contacts and ability to act as boundary spanners. A review of resource-dependency theory (Hillman *et al.,* 2009) found substantial empirical evidence to support the benefits to boards brought by NEDs, as proposed by Pfeffer and Salancik (1978). They contributed human and relational capital, brought resources such as advice and conferred legitimacy, and also provided channels of communication and access to others. The need to review board composition as external circumstances changed also received substantial support from their review of the literature (Hillman *et al.,* 2009).

In an earlier theoretical paper Hillman and Dalziel (2003) propose a model that combines agency and resource dependency theory. The contribution to the board of human and relational capital is positively associated with the provision of resources but, in addition, the knowledge brought by the NED also enables efficient monitoring (p.389).

These different theoretical perspectives suggest different roles for the individual NED on the board. These include protecting shareholder interests in an agency relationship with executives and/or working collaboratively with them to add value, in a stewardship relationship. The NED can also help the organisation respond to changes in the external environment, providing key resources and access to relationships. While these theories are helpful to some extent in understanding the role of the NED on a board, the resources he or she may be able to bring and the interests they may be able to represent, there is a lack of a single widely-accepted theoretical base (Tricker, 2015).

The monitoring role of the NED has been strengthened by a number of recommendations arising from influential reports and later codified. The duty to protect shareholders and stakeholders' rights is enshrined in the 2006 Companies Act. This raises an issue when it comes to the transfer of the NED role to the public sector, where there are no shareholders, and the question of whose interests the NED is there to protect.

The NED as a contributor to board roles in control and direction.

Rather than concentrating on the role of the individual NED, a different approach considers their contribution to the tasks of the board (Petrovic, 2008). Important considerations here are those Director behaviours and qualities important to enable the board to fulfil its roles in control and direction.

The behavioural aspects will be considered further later, after considering the tasks of the board. One approach to differentiating board functions is that of Tricker (1994, 2015), who developed a framework of the different board tasks in strategy formation, supervision of management, policymaking and providing accountability, and mapped these to the inward and outward focus of the board, as well as a present or future focus (figure 2.2).

Figure 2.2: Framework for analysing board activities (Tricker, 2015, p.46)

The activities in the left column are concerned with ensuring conformance; those on the right are performance roles concerned with the board's contribution to corporate direction. Conformance-oriented roles directors play include providing independent judgement, monitoring executive activity and

protecting the interests of other parties. Performance-oriented roles include strategic development and contributing wider business knowledge and experience, acting as a source of external information and connecting the board to useful networks (Tricker, 2015, p.323-325). These roles reflect the tenets of theories such as resource dependency theory and network theory, and involve the NED helping the board to recognise and respond to external pressures.

The Higgs review (2003) emphasised both conformance and performance aspects of the role, with NEDs expected to contribute to the development of strategy as well as scrutinising the performance of management in meeting agreed goals and objectives. These principles were incorporated into the UK Corporate Governance Code (Financial Reporting Council, 2012).

The ability of the board and external directors to contribute to the range of roles required in control and service has been questioned, particularly the ability of NEDs to be involved in the development of strategy. In a qualitative study of UK directors, the conduct and processes of the board, which either maximised or limited the opportunity for part-time members to be involved, led McNulty and Pettigrew (1999) to identify different levels of involvement. These range from the taking of strategic decisions, undertaken by all boards, to the shaping of strategic decisions, undertaken by some boards and then a greater involvement in the strategy process, which was achieved by only a few boards.

The limited involvement of part-time directors in strategic development was confirmed by Stiles (2001) in a multi-method study of directors in UK public companies. He found the board had less to do with strategy formulation than with ensuring that strategic activity did not stray too far from the organisational purpose. The actual formation of strategy was more likely to take place in executive committees before coming to the board. The board then played a gatekeeper role in setting the values and parameters within which strategic decisions were made and also had a confidence-building role by the scrutiny of the proposals by the NEDs (Stiles, 2001, p. 637). A qualitative study by Pye (2002), drawing on previous studies of UK companies, also found that boards could shape the strategic process, even if boards were rarely the originators of

strategy. A vital component of governing was found to be strategising – a process of dialogue and debate that shaped the organisation's future.

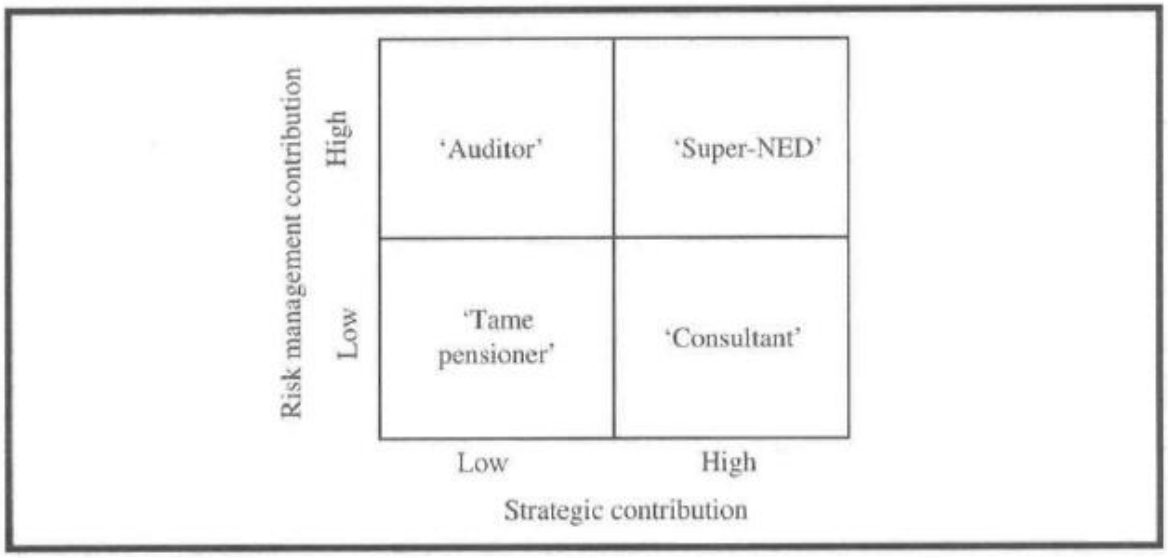
This process of dialogue between executives and part-time directors involved in strategy development and the different sort of relationship it entails between board members to that of the monitoring role have led some to question if the NED can be involved in both strategy development and monitoring.

Conformance vs performance roles?

For some scholars, these roles in conformance and performance are felt to be in conflict, with the greater involvement of NEDs with management, such as in strategy development, constraining their ability to act as an independent monitor (see for example Ezzamel and Watson, 1997).

The question of whether one person can fulfil the differing NED roles is posed by Pye and Camm (2003). They identify four types of NED contribution, shown in figure 2.3, which they map according to the level of involvement in risk management or strategy. They suggest that the types of NEDs boards need will depend on the internal and external context. The ‘consultant’ NED will bring specific required skills to work closely with executives in developing strategy, which will require a development relationship. The ‘auditor’ NED will be less involved, with minimal contact with the organisation and able to assess the level of risk of proposed strategic initiatives.

Figure 2.3: Four types of non-executive role contribution (Pye and Camm, 2003, p.66)



However, the distinction between the two roles is not always evident in practice, for example Spira and Bender (2004) consider the role of the NED on the remuneration committee to encompass both strategic and monitoring elements. Their examination of the NED role on the audit and remuneration committee finds that, in practice, the different types of relationships required by the different roles are not irreconcilable, nor do they present any practical difficulties for the NED.

In his study of directors in UK public companies, Stiles (2001), also found the NED able to combine both the conformance and performance role. In a later co-authored qualitative study, examining the role and effectiveness of NEDs on the board, the case is again made for the limitations of approaches that see the NED either in an agency or a stewardship role (Roberts, McNulty and Stiles, 2005). While there may be tensions between a conformance and performance role, the crucial issue is seen as the behaviour of NEDs and how they manage these tensions in their relationships on the board.

A behavioural approach is of particular interest to this study examining the role and contribution of NEDs, and is explored further in the next section.

Board behaviour and processes

Interviews with a range of senior executives led Mangham and Pye (1991) to identify important director qualities for leading companies. These are directors' reading of situations, where they interpret situations and then create or 'wright' a response. The use of the word is drawn from occupations such as a playwright who shapes something new, which reflects a particular moment in time, but is guided by tradition (Mangham and Pye, 1991, p. 27). Later, Pye (2013) refers to these qualities of reading, wrighting, and directors 'relating' as the three 'R's of effective director skills. For Pye (2002) governing is seen as a social and collective process, preferring the term governing to governance, with the actions of governing of interest. Reflecting on her qualitative longitudinal studies on corporate directors over the period of 25 years, Pye (2013) considers how the nature of the readings, the means by which directors 'wright' and respond, and the influence of key relationships will change depending on context and judgement. This interpretive approach was of interest when considering director roles in the public sector, where the different context might cause NED roles to read situations differently and shape the role differently in response.

A key function of the board is to lead the organisation as a group of executives and NEDs. The board has been described as a team (Sonnenfield, 2002) and more recently by Vandewaerde *et al.* (2011). To support their conceptualisation of the board as a team Vandewaerde *et al.* define a team as a collective that shares a common goal and have task interdependencies and social interactions within maintained and managed boundaries (p.405). Other scholars do not identify the board as a team (Stiles, 2001) but the board's role as a decision-making group (Forbes and Milliken, 1999), and an emphasis on board processes, is one that has received continuing interest (McNulty, 2013).

The effectiveness of the board as a decision-making group is considered by Forbes and Milliken (1999) to be hindered by factors such as the comparatively large size of the group, the infrequency with which the board meets and its minimal involvement with the organisation. Such factors are considered to have

the potential to lead to ‘process losses’ where the group fails to reach its full potential (p. 492). Drawing together literature on group dynamics and boards of directors, Forbes and Milliken suggest that for a board to be able to effectively discharge its duties in relation to control and service, there needs to be both high levels of cohesiveness and also task-oriented disagreement. This cognitive conflict is identified as one important factor in board-task performance, along with the effort norms extended by directors and the way that their knowledge and skills are utilised by the board. One advantage of this cognitive conflict is suggested as reminding management of the power and role of the board (Forbes and Milliken, 1999, p.494).

But how much power does the board have? While not the focus of the study by Forbes and Milliken, another stream of literature considers the power of the board and particularly the non-executive directors. This is of direct relevance to the current study, considering the role of the NED and the contribution they were able to make to PCT governance.

Examining power

Approaches to the study of power vary but, simply defined, it is the ability to affect the behaviour of someone else (Lucas and Baxter, 2012). Social psychology approaches often draw on French and Raven’s classic five bases of power: expert power, legitimate power, referent power, coercive power and reward power (French and Raven, 1959). Information power was added by Raven (1965) and he later summarises his earlier work and the subsequent canon of literature on this subject (Raven, 2008).

The board of an organisation has legitimate power. But within a unitary board it has been argued (Mace, 1971) that managers have greater power than the part-time directors, due to their superior expertise and access to all necessary information. However, the power of the part-time NEDs can be influenced by many factors, such as the proportion of NEDs on the board, which has increased over the years, legal authority and stakeholder expectations (Lorsch and MacIver, 1989). The behaviour of the NED and the skills they are able to

utilise to exercise power are other important factors (Pettigrew and McNulty, 1995).

In an examination of boardroom power Pettigrew and McNulty (1995) interviewed directors from top UK plcs to examine the contribution of part-time directors (the term is used to include both NEDs and Chairs). They develop a tripartite analysis of power and influence, examining the interplay of three elements, the power sources of part-time directors, their will and skill in utilising these, and the influence of context and structure. This is shown in figure 2.4.

Figure 2.4: The tripartite analysis of power and influence (Pettigrew and McNulty, 1995, p.854)

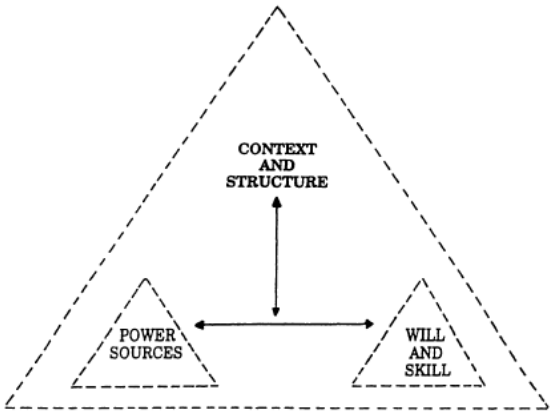


Fig. 1. The tripartite analysis of power and influence.

The manifestation of power is considered a dynamic process, dependent on context at both the micro and the macro level of organisational life. This includes legal frameworks and societal expectations of the board. While context and structure might be considered as constraining action, the authors draw on Giddens (1979), arguing that as these arise from the actions of people, so actions are both constrained by – but also contribute to – structure.

Power sources of part-time directors include their personal stature and knowledge of industry. However, Pettigrew and McNulty (1995) identify the behavioural aspects for this knowledge to be utilised; there had to be the will to act and the skill to be able to act effectively in different situations.

The potential power of part-time directors was found to be restricted, in part, by the norms of board conduct within a unitary board. The culture of the board is an influencing factor and two types of board are identified. Minimalist boards sought to limit involvement of NEDs, either by the way the board was structured, the attitudes of the Chairman or CEO, or board processes that limited input. Maximalist boards, on the other hand, enabled NEDs to have more sustained involvement and influence, with the attitude of the Chair a major contributory factor.

In a later paper, McNulty and Pettigrew (1996) consider how part-time directors were able to utilise sources of power. They identified several different methods of influence from a review of the literature, including persuasion (both reactive and proactive), coalition formation, assertiveness, consultation, pressure and blocking. Examples given by directors of contribution to the organisation were then analysed to identify the different methods of influence utilised. NEDs predominantly used methods such as persuasion, coalition formation, assertiveness, consultation and pressure with Chairs more likely to use assertiveness, consultation and pressure. Through such methods respondents contributed in five main areas – 'appointment, dismissal and compensation of board personnel; the conduct and process of the board; the strategy of the firm; culture and functions and the financing of the firm' (p.165).

The studies by Pettigrew and McNulty draw on data from a time when there were fewer NEDs on boards, whereas the proportion of executive to non-executive roles has now decreased and corporate boards are likely to have a majority of NEDs (Pye, 2013). One aspect of interest to the current study is how the NED role is shaped by societal expectations of the conduct of the board (Pettigrew and McNulty, 1995, p.856). In the previous section the concept of public value was considered and societal expectations of a public organisation, such as a PCT, so an area of interest is how differing expectations might shape the public sector board.

Additional areas of interest are whether the sources of power will be different for NEDs in the public sector, how these might be utilised and what might motivate

an individual to act. The task of monitoring the activities of the CEO is described by Kirkbride and Letza (2005) as a gatekeeper role for the NED. They identify a key incentive for the NED to take on this responsibility is their reputation, with an assumption that the NED will have a business career and assets outside of the firm, which would be adversely influenced by any monitoring failure in the NED role. This provides an incentive to act rather than to remain passive on the board in the face of poor CEO performance (p.544).

Of interest when considering how corporate governance practices might be different in the public sector is how this monitoring role may be incentivised, where a failure to monitor may not have the same reputational impact as NEDs come from a range of backgrounds. The perceived 'failure' of a public sector organisation may often be attributed to a range of causes emanating from Government policy, rather than solely attributed to board behaviour (though increasingly NHS boards have been held to account for organisational failures). The incentive to act within this gatekeeper role might be one area of difference within the public sector.

While few of the studies on NHS boards explicitly explore aspects of power, this has been a growing area of interest in the private sector since Pettigrew and McNulty's original analysis (1995, 1996, 1999). Subsequent studies have continued to explore the behavioural dynamics of corporate boards and the topic of power.

Using power and influence

In social psychology approaches, power and influence may be seen as all part of the same process. Power is the ability to get what one wants, even if resisted by others, and influence is the practice of using power to bring about behaviour change (French and Raven, 1959). Alternatively, in sociology's group-process approaches, Lucas and Baxter (2012) argue that power and influence within organisations are distinct processes. While both might achieve the same outcome – getting what one wants – influence is the ability to get people to perform actions not because of fear of reprisal or expectation of reward but

because they are convinced it is the correct action to take (p.58). They draw attention to negative aspects of the use of power, such as resentment by those without power.

While board members do have structural power accorded to them by their position on the board, what emerges from several studies on boards is the importance of the NED's ability to influence and convince others of the appropriateness of an action – the skill part of Pettigrew and McNulty's (1995) analysis. So, for example, in Samra-Fredericks' (2000a) ethnographic studies on boards and directors, she considers how directors use in practice the power sources identified by Pettigrew and McNulty (1995). She identifies how skills, such as conveying respect and acting with diplomacy, are utilised, allowing maintenance of 'face' during interactions between directors to build trust and effective influence (2000b, p. 316).

The importance of board dynamics was confirmed by Stiles and Taylor (2001), in their multi-method study of directors in UK public companies. The development of trust and of constructive relationships between NEDs and managers were found to enhance board effectiveness, with a monitoring role by the NEDs considered only necessary in exceptional circumstances (Stiles and Taylor, 2001, p.118). NEDs are found not to consider themselves as a team with the rest of the board, contrary to the views of Sonnenfield (2002), with a fine line to be drawn between too cosy a relationship with executive directors or an equally undesirable 'them and us' relationship (p.113). The NED role is seen as one requiring active negotiation over time with the social order of the board arising from 'a complex interplay of context, individual abilities, and structural conditions' (Stiles and Taylor, 2001, p.122), and confirms the findings of Pettigrew and McNulty (1995), that actions in the past influence the context for the exercise of power in the future.

The dynamic nature of relationships within the board was highlighted by Roberts (2002) in his qualitative study on the role of the UK plc Chair. He found the very presence of the NED on the board created accountability and influenced executive behaviour. In anticipation of being held to account,

directors ensured that proposals and information being presented to the board are of a high quality.

In a later co-authored study, commissioned as part of the Higgs review and drawing on interviews with company directors, Roberts, McNulty and Stiles (2005) examine the behavioural dynamics of boards. Challenging the dominance of agency theory they suggest a key role for the NED is in creating accountability for executive performance through a range of behaviours – such as challenging, questioning, testing and exploring – which draws upon the NED's experience (p. S12). Earlier in this chapter it was identified as an area of debate, the ability of the NED to operate both in a monitoring role and a supportive one, with greater involvement seen as limiting the ability to bring in external scrutiny. NEDs, with the right skills, are found to be able to manage these tensions described by Roberts *et al.* (2005, p.S21) in terms of three couplets: engaged but non-executive, challenging but supportive, and independent but involved.

The behaviour of the NED can therefore be seen to be an important factor. A NED may have different sources of power arising from his or her status on the board and professional expertise, but to be effective NEDs need to have interpersonal skills to be able to influence executive behaviour and to create the accountability and the positive dynamic as described by Roberts *et al*. (2005). In a response to the study by Roberts *et al*., Pye and Pettigrew (2005) stress the importance of context in determining what might be considered effective board behaviour at any particular time. Drawing on their previous studies in this area, they highlight an additional necessary quality for a NED, the ability to act in a conceptually appropriate manner in response to different situations (p. S35).

Effort norms

The impact on board performance by effort norms, such as the seeking out by directors of additional information, preparation for meetings and engagement in critical debate, have been an increasing area of interest. The importance of NED behaviour and commitment for the tasks of the board are confirmed by international studies. In a study on Italian CEOs, Minichilli *et al.* (2009) found

that board members' commitment was more important than board demographics for predicting board task performance and, in a later comparative study of Italian and Norwegian companies, that effort norms had a positive effect on both control and advisory tasks of the board (Minichilli *et al*., 2012). The impact of effort norms on the control function of the board was also a finding from a survey of Chairs in United States companies (Rutherford and Bucholtz, 2007). Director effectiveness as a monitor of executive behaviour was dependent on their ability to proactively gain, interrogate and probe information to address the information asymmetry with management.

These behavioural studies from the private sector increase our understanding of the types of behaviour that can contribute to board effectiveness, whether NEDs' preparation for meetings, the proactive seeking out of information, and a relationship with executives that emphasises both teamwork and challenge (Pye, 2013). An area for this study to explore further is whether the public sector context calls for similar or different behaviours and how they contribute to effective performance, acknowledging that this may be judged differently.

The Chair, as leader of the board, has a particular role in helping shape the board dynamics. This role is examined further in the next section.

The role of the Chair

When considering the role of the Chair in the NHS, Chapter One showed there were two aspects of the role, as a leader of the organisation and as a leader within the broader health and social care economy. As the first aspect is similar to that within the private sector, the literature from this sector was examined to consider this particular aspect of the role of the Chair.

In a qualitative study of Chairs in major UK companies, Roberts (2002) examined how Chairs and NEDs complemented or added value to the board. The responsibility of the Chair in this regard was the appointment of NEDs with complementary skills to the executive and then creating the right conditions for non-executive effectiveness, such as ensuring meetings were focused, stimulated discussion and generated openness and trust. The Chair was able to

maximise the potential of these complementary relationships through structuring both formal (board and committee) contact as well as informal contacts between NEDs and executive directors (p.509). The role of the Chair in enabling a balance of contributions across the board and in creating the right board environment and dynamics, where NEDs are able to contribute, confirms earlier findings (Pettigrew and McNulty, 1995).

The role of an effective Chair in helping create the right conditions for board contributions, with a positive climate of exploration and dialogue and able to manage the board dynamics, was further confirmed by Kakabadse *et al.* (2006), as was the impact on governance of the relationship between CEO and Chair. In their qualitative review of the role of the Chair, drawing on observations and interviews across four different UK boards, the authors draw attention to the importance of context, particularly company performance and the nature of critical decisions required. However, the study does not give any contextual information on the four boards studied or how this influenced the role of the Chair. It also does not expand on the boundary-spanning role of the Chair, concentrating on his/her organisational role, a feature of much of the research on the Chair role.

For Vandewaerde *et al.* (2011) in his conceptual model of shared leadership within the board, the Chair plays a critical role as moderator within the boardroom, monitoring, regulating and balancing members' contributions so that it can act as a group of peers and co-creators (p. 414). The role of the Chair with regards to creating a positive boardroom culture has been confirmed by several studies, helping to define clear group goals as well as norms of behaviour (Carter and Lorsch, 2004; Pye, 2013).

The Chair of the organisation is therefore seen as playing an important role in setting the tone of board discussion, helping board members work together as a decision-making group, with roles for the NED in providing challenge yet also working in partnership. The role of the Chair in helping focus board attention on the goals of the organisation is a relevant one for this study in the public sector. Earlier, this chapter considered expectations of the PCT board as a public

sector organisation with associated public values. How this ‘publicness’ might be expressed and the role of the Chair in guiding the organisation is an area to explore further.

Section summary

An overarching area of interest for this study is how corporate governance practices within the public sector might be different to that within the private sector, concentrating on the role of the NED and Chair. This section has given an overview of literature relevant to the role of the NED on a UK unitary board to identify key aspects of the role and different areas of NED contribution. This will be compared to the empirical findings of this study on the role of the PCT NED and Chair.

Theoretical approaches to the role of the NED include agency and stewardship theories, which suggest different roles for the NED vis-à-vis executive colleagues, such as monitor or collaborator, though studies show NEDs able to combine the roles and able to manage any tensions that arise. The NEDs is also able to act as a resource for the board, providing essential knowledge and connecting the board to useful networks. Other relevant theories such as stakeholder theory see different NEDs able to represent different stakeholder interests on the board, in a challenge to the dominance of shareholder interest.

Other approaches to the NED role see them as contributing to the task of the board, with NEDs contributing to conformance and performance-oriented board roles, including scrutinising the performance of management in meeting agreed goals and objectives as well as contributing to the development of strategy.

Increasing attention has been paid to the behavioural dynamics of the process of governing. Refuting earlier studies which considered NEDs to have little power compared to the full-time manager, sources of power for NEDs have been found to include relevant knowledge and the ability to draw on internal and external relationships, although the exercise of power is found to be a dynamic one, both influenced by and influencing context and structure, plus the individual skills and motivation of the NED (Pettigrew and McNulty, 1995).

The different accountabilities of the PCT board shown in Chapter One (figure 1.1) suggest a complex interplay of power relationships for the PCT, not only with an array of external stakeholders but also within the board, between non-executives, clinicians and managers, the latter of whom will also be influenced by the SHA to whom they are also accountable. The examination of power is therefore an important one for this study, helping to understanding how decisions might be reached between local and national priorities and also how the practice of governance might be different within a public sector organisation than to a private one. The role of the Chair has been found to be influential, not only in helping shape the degree of involvement a NED can have but also in setting the norms, values and culture of the board and organisation (Kakabadse *et al.,* 2001, 2006; Pye, 2013).

The influence of context on the NED role has been suggested for further consideration (Pye and Pettigrew, 2005) as well as other factors that may cause individual directors to act differently within the same organisational context. The next section examines how the strength of identification with different identities may influence the NED role.

The influence of identity on governance roles

In their review of board research Huse *et al.* (2011) refer to the insights into identity and board roles suggested by a study by Hillman *et al.* (2008). This is suggested as an area for further research, to help understand not only what is driving board members to be involved, but also for whom – which stakeholders they see their involvement as benefitting.

The assumption in much of the literature that outside directors will necessarily work to protect the interests of shareholders is challenged by Hillman *et al*. (2008) who suggest governance roles will be influenced by the salience or strength of identification with a range of identities held by individuals. The salience of an identity and its influence on behaviour will depend on the relevance of that identity to a situation and also how strongly the individual identifies with that role or social identity (p. 443). Hillman *et al.* develop a conceptual model utilising social identity and identity theories to suggest how

interests may influence behaviours within the boardroom. Identity theory arises from a sociological perspective and discusses the organisation of behaviour in terms of role behaviours and role identities. Social identity arises from social psychology and involves the categorisation of self and others to a particular social group, with defining characteristics, and considers how membership of a social group influences behaviour.

Five relevant identities for directors are suggested by Hillman *et al.* (2008, p.445) as being a director, CEO, shareholder, organisational and stakeholder (customers and suppliers). The strength of these identities is then hypothesised as influencing the role of the director in monitoring or providing resources for the organisation. So, for example, it is suggested a strong identification with the director role, the organisation, or shareholders will have a positive relationship with both a monitoring role and also provision of resources. However, if the director has been previously, or is currently, a CEO elsewhere, they are considered to be more likely to bring resources in but to have less of a monitoring role. This is attributed to the NED identifying with the CEO and considering how they might, in the same position, resent such monitoring (Hillman *et al.,* 2008, p.447).

This focus on identities, particularly social identities, and how they might influence the governance role was identified as relevant when considering the overarching questions for this research. The range of stakeholders is different in the public sector so identification with a particular group may have a different influence on the governance role when compared to the private sector. As discussed earlier, the initial PCT NED role had a representative aspect and there were continuing expectations that they would represent certain patient or local interests. Social identity approaches are therefore an area of interest to explore further, but rather than test Hillman's propositions through a quantitative approach, this study will explore social identity as one influence on the NED role.

A social identity approach

Self-categorisation theory, part of a social identity approach, considers the

categorising of oneself as a member of a group with distinct characteristics. In a process known as depersonalisation, a person aligns his or her actions with what they see as the normative behaviours of that particular social identity (Hogg *et al*., 1995, p.261). The extent of this alignment will depend on the strength of identification or salience of that particular identity (Ashforth, 2000).

The important factor is the identification the members make with a particular group, which influences how they bring their behaviour into line with the group prototype, rather than just being a member of a group (Augoustinos *et al*., 2006). Self-categorisation by individuals leads them to adopt the behaviour felt appropriate for that group or role (Hogg and Terry, 2000). In considering self-categorisation Pennington (2000) identifies a number of indicative factors, such as the extent to which people use the word 'we' to refer to the group, the use of direct reminders of being a member, such as the use of title or labels, and the identification of 'out-group' members (p.107).

A person will have many social identifications, not all of which will be activated or salient at any one time; rather a few identifications will be selected to suit the particular social context (Augoustinos *et al.,* 2006, p. 31). Which ones a person chooses to activate in a particular situation will depend on factors such as the strength of the identification and the context.

Social categorisation theory is suggested by Knapp *et al*. (2011) in a theoretical paper as a useful lens to study governance, focusing on how group identification may influence behaviours. Whereas Hillman *et al*. (2008) examine the influence of social identification with the organisation, shareholders or stakeholders, Knapp *et al.'s* (2011) unit of focus is the board. They suggest that within a board situation the salience or distinction made between directors and managers as two distinct social groups can vary according to the organisational context, such as a crisis in performance.

Cognitive biases can arise from self-categorisation to include a more favourable evaluation of the group the individual belongs to rather than those perceived as being the 'out-group', so Knapp *et al*. (2011) propose that the greater the salience between directors and manager, the greater likelihood of viewing the

other group more negatively, leading to more biased thinking and detrimental relationships.

Organisational identity is founded on social identity theory (Jones and Volpe, 2010), with members defining themselves by similar attributes to those they believe the organisation has. The stronger the identification, the more likely the individual is likely to work for its benefit. The extent of identification and how it affects the attitudes, behaviours and commitment to the organisation will have a direct impact on value creation for the organisation (Ashforth and Mael, 1989).

A qualitative study by Golden-Biddle and Rao (1997) in the not-for-profit sector found part-time board directors became organisational members to varying degrees through identification with the organisation. While this could bring benefits, it could also result in potential inter-role conflict, stemming from the director occupying roles as both organisational member and board member, with potentially conflicting expectations such as between a friendly colleague and vigilant monitor (p.595).

The use of social identity approaches in this study will explore how salient identities, such as with stakeholders, may influence the NED role. It may help illuminate ways in which corporate governance in the public sector is different to its practice in the private sector.

2.3 Corporate governance in the public sector

Corporate governance in the public sector draws on practices from the private sector. As seen earlier, its introduction can be seen as part of NPM reforms, with an emphasis on increasing organisational efficiency in the delivery of public services. However, while the influence of private sector practices is widespread, its utility in the public sector has been questioned (Osborne, 2006). An area of interest for this study is how the role of the board may be different within the public sector, providing a nationally-funded service that is accountable to Government as well as responding to differing societal expectations of a public sector organisation (Williams *et al.,* 2007).

Drawing on various empirical studies of governance in the public and non-profit arena, Cornforth (2003) considers the various corporate governance theories identified earlier in this chapter, such as agency, stewardship and resource-dependency theory. He concludes that, if taken individually, these theories fail to address the complexity and dynamics of organisational governance within the public sector. He proposes instead an approach that focuses more explicitly on the 'paradoxes, ambiguities and tensions involved in governance'. He suggests three main tensions: Who governs – the tension between representative and professional boards; board roles – the tension between conformance and performance roles; relationship with management – the tension between controlling and partnering (Cornforth, 2003, p.11).

A review of the public sector governance literature by Hinna *et al.* (2010) found the issue of the accountability of public sector boards and how different interests are served and negotiated to be a dominant theme. Agency theory is found to be an important stream within the literature, with agents still assumed to maximise their own utility and mechanisms to address this, such as ownership incentives, absent in the public sector. There is no direct relationship between the principal, which is taken to be the public, and the agent. Rather, the relationship is considered in two parts, the public to politicians and the politicians to managers, which leaves the wishes of the public open to exploitation or frustration by politicians or managers. Accordingly, Hinna *et al.* (2010) suggest that alongside the board's role in negotiating the potential conflict of interests of different stakeholders, there still needs to be a controlling role (p.144). The review includes public sector studies from across the world, including studies of organisations with stakeholder boards and elected representatives, so an emphasis within studies of how representative the board was and how different interests were served and negotiated is not surprising.

Additional roles for the public sector board, compared to the private sector one, arise from the influence of public governance (Osborne, 2006) discussed earlier. A theoretical paper by Gnan *et al.* (2013) identifies the tasks of the public organisation board as needing to go beyond organisational oversight to include broader inter-institutional governance and collaboration with stakeholders.

However, the addition of these new elements alongside the compliance-oriented aspects of NPM can cause tensions, as discussed earlier with reference to Newman's models of governance (2001). The next section focuses on corporate governance in the English NHS to assess how governance has been understood and conceptualised.

Corporate governance in the NHS

There is limited research on NHS boards and even less on the role of the NED and Chair in this context. There is a more developed field of research considering NHS Foundation Trusts and relationships between the unitary board and the council of governors (Dixon *et al.,* 2010; Exworthy *et al*., 2011; Allen *et al.,* 2012) and while these do not have as their focus the role of the board or NED, of relevance to this current study are findings of the continuing dominance of hierarchical, rather than local, accountability.

As seen in Chapter One, one way of increasing accountability and enabling different stakeholder interests to be represented was through the creation of NHS Foundation Trusts, with a membership structure and elected boards of governors. These Trusts were not accountable to SHAs in the same way as other Trusts were but authorised and regulated by a regulatory organisation, Monitor. However, a study by Dixon *et al*. (2010) found significant tensions with the SHA still exercising some control over NHS Foundation Trusts and the vertical accountability still the dominant one, rather than to the board of governors or local population, while Allen *et al.* (2012) found not all governors felt able to contribute to decision-making within Trusts, and the expected increase in local accountability yet to be realised.

PCTs had different accountability structures to NHS Foundation Trusts and the ongoing concerns as to their accountability to local communities were discussed in Chapter One. This was a particular area of interest for this study, the tension for boards of public sector organisations between acting in the local and national interest. Those studies on NHS boards that have examined this tension are considered in the next section.

NPM or post-NPM influences

The first section of this chapter considered the impact of NPM on healthcare and subsequent post-NPM approaches, such as public governance (Osborne, 2006). This was the area of interest for a qualitative, multiple case study by Veronesi and Keasey (2010, 2011, 2012). They investigated a range of NHS organisations in 2008 to identify if boards were operating to an NPM paradigm, characterised as ensuring efficiency and value for money, or a post-NPM paradigm, characterised by interorganisational collaboration and devolved decision-making power closer to the final user or citizen. NPM principles were still felt to dominate, where the added value of the boards was seen in the forms of efficiency gains and improved outputs, with a reliance on performance measures (2011, p. 872).

Only a small number of boards (considered as operating to post-NPM principles) saw their first priority as high-quality healthcare services, where the added value was considered to be higher effectiveness and better quality outcomes. The NHS organisations investigated are seen as influenced by a hybrid model of governance that legitimises different behaviours, such as the dominance of the expert, in response to bureaucratic, market and network principles. The domination of NPM values is attributed by Veronesi and Keasey to a governance model that stifled dialogue, with financial and clinical expertise allowed to dominate board discussions rather than exploring more collaborative approaches to complex issues. Behavioural dynamics are therefore identified as an important factor in the pursuit of public value and more collaborative governance approaches (Veronesi and Keasey, 2011, p.852). The studies have a greater emphasis on the manager-clinician relationship and the NED is seen to play only a marginal role.

The studies by Veronesi and Keasey (2011, 2012) were across different types of NHS organisations, including PCTs, but they acknowledge that they concentrated on its functions as a provider of care (community services) rather than its commissioning role. In the latter paper they concentrate more on NHS Foundation Trusts but it would have been useful to have a greater exploration of

the role of PCTs as commissioners of services. Tasked with improving the health of their communities, PCTs were expected to work collaboratively with patients, the public and other stakeholders in identifying health needs and aspirations (DH, 2007) in a role quite different to that of a Trust providing health services.

One of the few studies to concentrate on PCTs, rather than across all NHS organisations, was by Abbott *et al.* (2008). They studied the boards of primary care organisations across Wales (a different model to PCTs) and England in 2005, including 10 PCTs. From their analysis of board minutes and observations of board meetings they found strategy – and often operational matters – largely determined by central Government, with limited ability of PCT boards to act autonomously. An estimation of power was made on how many decisions were taken, as recorded by board minutes. The board is perceived as having little power; however, the authors acknowledge the limitations of minutes in assessing this. Boards were found to pay more attention to second-order functions of finance, corporate governance and administration rather than first-order functions of providing or commissioning healthcare (p.49). They do acknowledge, though, that these might be functions of the Professional Executive Committee.

The findings with regards to the role of the NED will be examined further. However, of relevance here are the findings of the limited power of the PCT board, who appear as agents of central Government. Rather than seeing the boards of PCTs as accountable bodies, it is suggested that they be seen as part of a policy network where accountability is shared across a number of partners and multiple agendas are negotiated across organisations and interest groups (Abbott *et al.,* 2008, p.57). This suggestion is not explored further, such as the impact this might have on the role of the board or the NED. While not referencing NPM or post-NPM directly, the recognition of a need for a more-networked form of governance reflects post-NPM approaches, such as public governance (Osborne, 2006, 2010).

The aspect of accountability and the role of the PCT board was an area of interest that arose from a major study on governance in the NHS undertaken by

Storey *et al.* (2010). The aims of this study included an examination of the policy drivers for new governance arrangements and how key participants understood these. This included specific research into PCTs.

The findings show the number of competing pressures the PCT board felt under and the dilemmas of accountability, whether to SHA, to regulators or to local people. There is found to be a lack of clarity around the role of the board in providing accountability, and to whom, with dissatisfaction with the governance status of PCTs arising from the perceived interference by the SHA (Storey *at al*., 2010, p.90).

PCT boards faced challenges of whether to prioritise locally-determined outcomes or centrally-imposed ones, and the study suggests the board is a site of collective sense-making of these different messages.

However, what might influence the board's decision making or the contribution of different board members is not explored, nor are there any theoretical implications arising from the study (p.186). The study does though reveal the different tensions and 'pulls' towards different types of behaviour by the board due to differing government policies, as suggested by Newman (2001).

This section has examined how NHS boards have worked with complex accountability relationships, which are quite different to those within the private sector. The next section considers more closely the work of the board and the operation of corporate governance within the NHS.

NHS Boards: Exploring the practice of corporate governance

The main guidance documents for NHS boards, relevant to PCT boards, were *Governing the NHS* (NHS Appointments Commission and DH, 2003) and *The Healthy NHS Board: Principles for Good Governance* (National Leadership Council, 2010). These identified key roles for the board in monitoring, strategy development and, in the latter publication, helping shape the culture of the organisation. Chambers *et al.* (2013) examine the underpinning theories of the guidance for NHS boards and identify the dominance of agency theory, with its emphasis on the board's responsibility for quality and performance monitoring.

This is seen as problematic for health service boards, with its inherent assumption that the board's main role is limited to detecting managerial neglect or malfeasance, reducing the board's role in setting mission and values (p.35). Their review of a range of literature across the public and non-profit sectors concludes that social performance criteria are as important as financial ones. Within the healthcare sector this means a focus on patient outcomes and experience (p.81); the mechanism needed to achieve this not well understood, however.

Private sector-style boards were introduced in the NHS in 1992. The presence of clinicians on the board was found to add complexity to a simple executive/non-executive relationship by Mueller *et al*. (2003), who examined the introduction of corporate governance in an NHS hospital trust. Rather than finding a unified archetype or what they describe as the usual professional-managerial dichotomy they identify three interpretive schemes: Ideological–New Public Management, Executive Pragmatism and Medical Professionalism. The first is seen as represented by NEDs who use a challenging script, with the focus on financial performance. Where the challenging approach failed, NEDs resorted to a critiquing script. Executive directors took a pragmatic role, mediating or cautioning. The medical directors use a defending script, drawing on their professional power and seeking to maintain control of services and resources (p.1989).

Of interest in this early study is the emphasis on the NEDs' conformance-oriented role in monitoring and challenge, rather than performance-oriented aspects such as the contribution to strategy. This aspect of the role appears less prominent until the 2003 guide for NHS boards (NHS Appointments Commission and DH, 2003), which may reflect the greater freedoms envisaged for NHS Trusts (DH, 2001).

The strategic role for NEDs causes Ashburner (2003) some concerns, considering that this might compromise the NEDs' role in monitoring. She draws on studies in NHS Trusts in 1996, which she co-authored, that showed NEDs were increasingly being drawn into committees and what she considered

management tasks, which she felt limited NED objectivity and the ability to evaluate and scrutinise.

This view differs from the studies from the private sector, discussed earlier, where, in practice, a NED seems able to manage the tensions between a conformance and performance role (Stiles and Taylor, 2001; Roberts *et al.,* 2005). Later studies on NHS boards focus on the time spent on these two aspects of the board role, rather than examining any tensions the two roles might present.

Guidance produced for NHS boards (Appointments Commission and Dr Foster Intelligence, 2006a) suggested that 60 per cent of the board's time be given to strategic matters. While no evidence base for this was given, this has often been interpreted uncritically to be 'best practice', and for NHS board performance to be assessed against this. A study by the Institute of Chartered Secretaries and Administrators (ICSA) (2011) found that while the majority of respondents to their board questionnaire believed their board spent the appropriate amount of time on strategic matters, analysis of board agendas showed strategic items constituting less than 60 per cent of the agenda, so was identified as a 'gap in reality'. A three-year annual postal survey of Chairs and CEOs into governance in the NHS between 2007 and 2009 (Association of Chartered Certified Accountants, 2010) also found respondents considered NHS boards to concentrate too much on monitoring rather than strategy.

The limitation of these surveys is that they do not explore exactly what might be considered 'strategic' in a particular context and how the allocation of the board's time might be determined by the particular circumstances of the organisation at a given time.

In addition to considering how the board allocates its time to strategic, performance or clinical matters, another focus is how board behaviours might impact on its effectiveness. As seen from the review of corporate governance in the private sector, this is an established research stream but is less developed in studies of governance in the NHS.

A behavioural approach

A key focus of many of the studies of NHS boards is the presence or absence of challenge by directors, with a lack of constructive challenge identified as leading to managerial or professional capture (Veronesi and Keasey, 2010, 2011). However, the presence of trust, alongside challenge, as an important requisite for effective board relations is identified as important for NHS boards in a discussion paper by Bevington *et al.* (2005), drawing on work by the Board Development team within the NHS Clinical Governance Support team.

Empirical studies have used observations of board meetings, interviews with board members and analysis of board meetings to try and gauge the amount of challenge and trust present. Trust has been found to be the predominant feature of NHS boards, with a lack of challenge noted in many studies (Abbott *et al.,* 2008; ICSA, 2011; Veronesi and Keasey, 2011).

The collegial atmosphere at NHS board meetings, with no obvious conflicts, was also noted in a study by Endacott *et al.* (2013), although its main focus was on the clinical involvement of boards and public accountability. They undertook data collection between 2008 and 2009 examining board papers and observing board meetings of a number of NHS organisations, including four PCTs, to assess how much attention was given to clinical matters. An important observation, when considering board minutes as a source of data for governance research, was that board minutes were not always found to be accurate reflections of the discussions observed.

A methodological weakness is the use of boardroom observations to try and determine board behaviour, as the presence of members of the public has been argued to hinder honest discussion (NHS Confederation, 2005). In their studies of a public partnership board, with a range of stakeholders, Peck *et al.* (2004) consider the public board meeting to be more of a social ritual and performance, and to be studied as such, rather than viewing it as an instrumental process of decision making.

The behavioural studies on NHS governance concentrate on the balance of trust and challenge exhibited within the board rather than examine in any depth issues such as power. However, Veronesi and Keasey (2010) in a negative appraisal of the NHS boards in their study, view them as lacking power and able to do little more than rubber-stamp decisions. This is ascribed to a lack of board member ability, access to data, awareness of the broader organisational context or of their primary responsibility to local people rather than to simply implement central initiatives. The authors recommend a much greater focus on improving board behaviours and processes, with a perceived overemphasis on board structure and the role of the Chair and CEO (Veronesi and Keasey, 2010).

None of the studies on NHS governance have as their core focus the role of the NED; rather, there are scattered observations on the role, which will now be considered.

The NHS NED and Chair role

For Veronesi and Keasey (2010, 2012), a lack of clarity of board roles is found to lead to tensions between executives and NEDs. The latter are found to be marginalised and disempowered; this is attributed to their lack of information and knowledge about the organisation, in addition to behavioural dynamics that privileged individual perspectives above more collective and collaborative ones (Veronesi and Keasey, 2012, p. 283).

The two main studies on PCT boards by Abbott *et al.* (2008) and Storey *et al.* (2010) do not examine the NED role through any particular theoretical frame, nor is it the specific focus of their studies. They do though make some findings on the role of the NED. Abbott *et al.* (2008) find the NED monitoring role was taken seriously by executive officers and also that they had some input into strategy, though this mostly took place outside of board meetings. NED involvement in subcommittees is seen as a way of influencing emergent strategy as ‘critical friends’ (p.57). Their study is the only one to consider the role of the NED outside of the boardroom, which suggests a need for a wider study exploring the NED role and opportunities for influence outside of the usual focus of analysis, the public board meeting.

Tensions in the PCT NED role were identified by Storey *et al.* (2010). NEDs were found to be aware of their corporate role and the need to remain strategically focused, but often faced dilemmas between this and their desire for involvement in more community engagement and to raise issues of concern for constituencies they felt they represented (p.203).

The studies by Storey *et al.* (2010) confirm the findings of Veronesi and Keasey (2010) in identifying the lack of clarity amongst respondents as to the NED role. It also acknowledges the tensions for the PCT board of working with sometimes competing demands and different stakeholder interests. However, it does not explore how NEDs were able to contribute to this negotiation of interests nor the sources of power they may have been able to draw upon to have influence.

The influence of identity on the NED role

The influence of identify on board role is considered by Hogg and Williamson (2001). In a discussion paper they draw on concepts developed by Alford (1975) to suggest whose interests lay members on NHS boards and committees represent.

They suggest these fall into three categories – supporters of dominant (professional) interests, supporters of challenging (managerial) interests and supporters of repressed (patient) interests, while acknowledging that there will be ambiguities and subgroups within these main categories. Lay members who come from business, finance and management backgrounds are considered to be more likely to support challenging interests and managers but be less sympathetic to the needs of patients and health professionals. In a later discussion paper, Williamson (2008) views PCT boards as corporate rationalisers whose interests lie mainly in rational and cost-effective use of resources, with the majority of business people appointed as NEDs considered to support these interests and to be supportive of managers. Interests are defined as a stake the interest-holder has in something important to them, because of the 'benefit or harm it can do to him or her or the social group to which he or she belongs' (p. 512).

The use of Alford's concepts, formulated within a specific time and place (access to healthcare in New York in 1975) has been challenged by Checkland *et al*. (2009) for their relevance to the UK and a publically-funded system. However, Williamson's views on the NED role are interesting (Hogg and Williamson, 2001; Williamson, 2008) as they consider how background might influence the role. The perception that the majority of NEDs appointed since 2006 were from business backgrounds was also a finding from the study by Storey *et al.* (2010). But how this might influence how the NED role is perceived has not been explored further.

No further studies utilising a social identity approach to understand how different identities may influence board roles in the NHS were identified, although this has been used elsewhere in the public sector, in a study on University governance (Rytmeister, 2009).

The role of the NHS Chair

Few studies refer to the role of the NHS Chair in any depth. One study (Exworthy and Robinson, 2001) uses role theory and negotiated order theory to examine the relationship between the Chair and CEO in a range of NHS Trusts, using interviews with pairs of Chairs/CEOs. There was broad support for the division of roles between the Chair taking responsibility for the board and the CEO for the organisation, while acknowledging that roles overlapped in places, with the boundaries flexible and negotiated, influenced by personalities and context. Additional roles identified for the Chair were a public relations role, recognising the political aspect, as well as in providing public accountability.

The emphasis by Exworthy and Robinson on the value of a strong relationship between Chair and CEO is in contrast to studies carried out in the 1990s, which claimed a strong relationship could be detrimental to governance by diminishing the power of other NEDs (Ashburner, 2003, p.216). In a later study the Chair/CEO relationship was identified by Veronesi and Keasey (2010) as problematic in some Trusts they studied, particularly where the individuals had differing levels of experience.

The majority of studies focus on the internal role for the Chair and the importance of the role in setting the tone for board meetings and in enabling debate and contributions from NEDs (NHS Confederation, 2005; Endacott *et al.,* 2013). This supports studies in the private sector that identify the Chair as playing a key role in determining the depth of involvement NEDs are able to have in the organisation (Pettigrew and McNulty, 1995).

While it is the Chair's role in managing the board that has been the primary topic of research interest, the external-facing aspect of the role is an important aspect that has been largely overlooked. Of interest are the results of research into the selection of PCT Chairs in 2006 and consequent performance. This found a significant relationship between performance after one year in post, as judged by the SHA Chair, and the personal qualities of team working and patient and community focus, as tested at the selection stage by use of interviews and assessment centres (Alban-Metcalfe *et al.,* 2010, p.79). It highlights that the role of the Chair was not only seen as being broader than simply leading the PCT board but also to have an external political and public relations role, as identified by Exworthy and Robinson (2001).

Model of unitary board questioned

Various authors, notably Chambers (Chambers and Cornforth, 2010; Chambers, 2012; Chambers *et al*., 2013) and Selim *et al*. (2009), have carried out reviews of literature and made suggestions as to how NHS board organisational performance might improve with regard to quality and safety of healthcare. The lack of empirical studies into NHS governance means much of the literature considered comes from the private sector and models of healthcare provision outside of the UK.

The adoption of the unitary board model for healthcare organisations is questioned by Chambers (2012), who identifies this, and the rigid separation between strategy and delivery, as areas for further research. In a later co-authored study, she warns of public boards copying corporate governance practices from the private sector without sufficient regard for their appropriateness to the public sector (Chambers *et al*., 2013, p.78).

The NED role is identified by Ferlie and Ongaro (2015) as one requiring further examination. After a review of the public sector literature on corporate governance, with a focus on the NHS, they highlight in particular the need for further research to understand 'the extent to which (where and why) non-executives are able to combat senior management hegemony to carve out an effective role' (p.63). The language used indicates that issues of power are considered central to the issue of how NHS NEDs might contribute to governance and will be one of the concepts used to guide this study.

Summary

This study began by identifying two broad areas of research interest: how do private sector corporate governance practices work in practice in the public sector, using the NHS as an example? And how do the boards of these NHS organisations manage the tension of being nationally accountable while also being responsive to local need, where these national and local accountabilities may be in conflict?

Studies on NHS boards acknowledge the tensions brought about by needing to meet national performance targets while trying to be responsive to local need. These confirm the findings of broader studies on decentralisation within the NHS (Dowling *et al.,* 2008; Exworthy *et al.,* 2010). They reflect the tensions identified by Newman (2001) between a rational goal model of governance that emphasises NPM practices and centralised control through the meeting of national performance targets and the self-governance or open systems model. These models promote decentralisation and closer working with local people or within networked organisations.

Studies by Storey *et al.* (2010), Veronesi and Keasey (2011, 2012) and Abbott *et al.* (2008) acknowledge the tensions between different accountabilities and suggest ways they might be addressed, such as by seeing PCTs as part of an accountable network (Abbott *et al.,* 2008) or addressing the board dynamics (Veronesi and Keasey, 2011). These suggest that the model of corporate

governance, imported from the private sector, can be problematic, within the NHS and a publically-funded system, with regards to its role as a local organisation. This would support the views of Osborne (2006) that the intra-organisational focus of NPM is too limiting in the public sector, where there are multiple actors and a need for greater collaboration.

The focus on financial and organisational performance has been felt to be at the expense of strategic considerations. There is a recognition that NHS boards need to be able to negotiate the different interests of stakeholders, existing research, however, does not go beyond that to consider how that might be achieved or the role the NED might play in this negotiation.

While corporate governance practices such as the model of a unitary board and NEDs have been adopted from the private sector, compared to that sector the research into public sector governance is limited and undeveloped. A number of studies have examined the emergence of a new organisational form, the NHS Foundation Trust, and the relationship between the board and the council of governors (Dixon *et al.,* 2010; Exworthy *et al*., 2011; Allen *et al.,* 2012), but fewer have had as a focus the model of the unitary board and in particular the role of the NED.

Studies by Abbott *et al*. (2008) and Veronesi and Keasey (2010, 2012), while not focused on the role of the NED, consider that the role lacks clarity and is marginalised within the board, although there has been limited exploration of the power sources available to NEDs and Chairs and how they might use these to contribute to board governance. NEDs have largely been found to act in a conformance-oriented role, monitoring management, but there is little exploration of other roles for the NED as have been identified in the private sector, such as the contribution of human and relational capital (Hillman *et al.,* 2009).

These limitations of previous studies in exploring the NED and Chair role and contribution, and how it may be different to its conceptualisation in the private sector, led to the development of the research questions.

Research questions

This study proposes to explore the two broad areas of research interest posed above through the first-hand experiences of the PCT NED and Chair, with the research questions identified as:

1) *How did NEDs and Chairs perceive their governance role within PCTs and what influenced this?*
2) *What contribution, if any, did PCT NEDs and Chairs feel able to make to the governance of PCTs?*

Existing research on boards in the NHS has shown no clear theoretical approach. This study therefore proposes to draw on theoretical frameworks suggested by the literature from corporate governance in the private sector as influencing role and contribution.

Conceptual framework

Three possible influences on the NED and Chair role have been identified from the literature reviewed as of interest for this current study. The first is personal, the influence of background and social identity on the NED role. The second is the internal board context, considering the power of the NED to contribute and how he or she was able to exercise this power to make a contribution to governance. The third is the broader external context, the tensions introduced by different governance models and how these may influence the role of the board and its members.

The salience of different identities, whether external stakeholders, customers or the organisation is suggested by Hillman *et al*. (2008) as influencing the private sector NED role, whether in a monitoring or resourcing role, or both. This study will utilise insights from a social identity approach to examine if a salient or strong identification with any particular stakeholder group or the organisation influenced the PCT NED role.

To explore the different NED roles within the PCT, the framework suggested by Tricker (1994, 2015) of conformance and performance-oriented roles will be

utilised. The conformance aspect includes the provision of accountability and the monitoring of management. Performance aspects include policymaking and strategy formulation. Guidance for the NHS suggests both are important aspects, but existing studies have found the conformance-oriented roles to dominate.

When considering NED contribution then, the power of the NED in these roles is an important aspect, with previous studies in the NHS suggesting limited ability to influence management and the role to be a marginalised one. Aspects of Pettigrew and McNulty's (1995) analysis of power from private sector boards, examining the interplay of three elements, the power sources of part-time directors, their will and skill in utilising these, and the influence of context and structure, will be used to examine the power of NEDs and Chairs in PCTs. Particular areas of interest and suggested differences within the public sector are the power sources NEDs could draw on and the will to act. This links back to the influence of social identity and how NEDs may act to protect or further the interests of those groups they identify with.

The influence of the policy context on board roles is a further area of exploration. The model developed by Newman (2001) of different types of governance suggests how public sector organisations, such as PCTs, might be 'pulled' towards different types of behaviour. PCTs were originally seen as local organisations and the initial expectations of them appeared to have elements of Newman's (2001) self-governance form of governance, with a 'pull' towards devolution and participation but also towards an open systems model, based on networks. However, the practices of NPM had a major influence on NHS boards and a 'pull' towards the rational goal model of governance, with a shorter-term focus on performance measurement.

These governance tensions are suggested as a third area of influence on the PCT NED and Chair role, requiring different roles in response, which will be explored with reference to Newman's (2001) models of governance.

The Chairs of PCTs are also NEDs, but this study will also examine the distinct role and contribution of the Chair over and above the NED role.

While PCTs have now been abolished, the broader research areas identified as of interest, namely how private sector corporate governance practices work in practice in the NHS and the tensions for boards between national and local accountabilities, will be considered in light of the findings of this study to contribute to theory development and also practical implications for NHS boards.

The next chapter considers the methodological approach to the research.

Chapter Three: Methodology

This chapter outlines the (underpinning) philosophy and methods used in this research. It begins with an overview of the approach chosen and philosophical considerations. The second section discusses the research methods chosen, with the third section detailing the approach to sampling and recruitment, ethical issues and the interview process. The fourth section outlines the approach to analysis undertaken by the current study, based on Braun and Clarke's (2006, 2013) qualitative methods. The final section includes reflections on the research process and being an insider-researcher, and then addresses the issue of quality assurance.

3.1 Overview

The research approach of this study is an exploratory one; it seeks to understand how PCT NEDs saw their role and subsequently their contribution to the effective governance of the PCT in its role in providing and commissioning services to improve the health of their community. A qualitative approach is considered appropriate as it seeks to 'study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them' (Denzin and Lincoln, 2005, p.3). Methods used by qualitative researchers exemplify a common belief that they can provide a 'deeper' understanding of social phenomena than would be obtained from purely quantitative data (Silverman, 2010). One of the strengths of qualitative research in management studies is its ability to give 'voice' to how individuals experience and interpret their experience (Bluhm *et al.,* 2011, p.1870). It is this deeper, possibly not yet previously surfaced, experience of NEDs and Chairs that is of interest here.

Qualitative research can be used to test or generate theory but also to elaborate on existing theory, with the study design derived from existing conceptual ideas (Bluhm *et al.,* 2011). This is the approach taken here. This study is grounded in the first-hand experiences of non-executive directors and chairs, gained through

semi-structured interviews but informed by concepts identified by a review of the literature and presented at the end of the Chapter Two.

As all research – no matter how carefully executed – can bring with it the biases of the researcher, steps need to be taken to minimise them wherever possible. In addressing this, Braun and Clarke (2013) emphasise that it is important for researchers to be transparent about the assumptions that underpin their approach, as different sorts of knowledge are produced within different theoretical frameworks. This will now be considered.

The philosophical perspective

The philosophical stance of the researcher includes consideration of both ontology and epistemology. Ontology concerns the assumptions a particular approach to social enquiry makes about the nature of social reality, and epistemology refers to the assumptions made about the ways it is possible to gain knowledge of this reality (Blaikie, 2007, p.3-4). Ontological positions tend to exist along a continuum, where a realist approach is at one end, which sees reality as entirely separate from human ways of knowing about it, while a relativist approach is at the other, where reality is seen as entirely dependent on human interpretation and knowledge (Braun and Clarke, 2013). Epistemology can also be realist or relativist. A realist approach assumes that access to 'the truth' can be gained through the production of legitimate knowledge. A relativist approach rejects the possibility of a single, absolute truth, but rather assumes that any understandings of this this external world will be limited, 'strongly bounded by a particular time and specific context' (Diaz Andrade, 2009, p.44). However, a relativist approach that does not acknowledge a world beyond the intersubjective one is described by Layder as 'naïve subjectivism' (2008, p.141). Although, some have argued that 'objectivity' is no more than 'intersubjectivity' such as Karl Popper (1976), a philosopher of science.

A critical realist approach adopts a middle ground in the realism-relativism continuum, both subjectivist and objectivist in its presuppositions. For Layder, a critical realist perspective takes into account both the layered and textured nature of social reality (the ontological depth) and an epistemological basis that

reflects the interweaving of objective and subjective elements of social life (2008, p.27).

A critical realist approach is the one to be used for this study. The accounts given by respondents of their NED/Chair role are treated primarily as informative accounts of their experiences rather than as performances or constructions. Thus the themes produced relate these experiences of the role 'as lived' for the participants. However, there is also a degree of 'hermeneutic suspicion' about what is being said, recognising these accounts are co-constructions performed and achieved in a specific context, that of the interviewer asking them to describe a role or present different incidents. This hermeneutic of suspicion (Ricoeur, 1981) means thinking critically about these performative aspects – how a participant has constructed their account and the position they adopt, as well as what is not being said.

This study will follow the adaptive theory approach of Layder (1998), which is underpinned by a critical realist methodology. Another theoretical perspective, grounded theory (Glaser and Strauss, 1967), which has a long history within health research (Holloway, 2005), was also considered but rejected. One of its main pillars – that of theory building as the research progresses – was an attractive idea but is not appropriate for this study. Adaptive theory seeks a middle ground between approaches such as grounded theory, which sees theory as emerging only at the end of the research process, and those approaches shaped by pre-existing theory. Contrary to a grounded theory approach, Layder (1998) argues the need for consideration of prior theory and conceptual model, and a dialogue between these and the conceptual elements that emerge as an adaptive response to data analysis (p.155). The adaptive theory approach he suggests is a continuous process of using existing theories and, based on these and their interplay with empirical data, developing new theoretical ideas, insights and theoretically informed concepts and understandings. Initial orienting concepts shape the enquiry; however, in the course of data analysis new themes may emerge that may mean the original concepts are modified or further developed (Layder, 1998, p.110).

3.2 Research approach

The German word '*verstehen*' (understanding) was reworked by sociologists and historians in the mid-nineteenth century to encompass the subjective sense making of the individual's experience, in contrast to the then dominant philosophy of positivism and explanation. 'The individual is seen as holding membership in a community of meaning, such that his subjective perception and understanding themselves draw on the repertoire of collectively created and sanctioned meaning particular to that community and shared within it by its members' (Yanow, 2006b, p.10). The approach of the researcher is therefore not to simply investigate the subject of interest but to actively understand 'from within' the community, to get inside the head of the actor, though whether this is really possible is debatable (Schwandt, 2000, p.192).

To 'understand from within' the NED community meant an approach that accessed their own accounts of governance and heard respondents' own words. A study of NED involvement in decision-making through the analysis of board and committee minutes, the approach taken by Abbott *et al.* (2008), may have generated interesting material, but not the individual and personal accounts that were sought in order to answer the research questions.

Research methods: Choice of approach

The principal method of data collection was semi-structured interviews with a purposeful sample of 52 NEDs and Chairs from 37 PCTs across England. This was supplemented by secondary data from board minutes and news reports, which provided some of the broader organisational and wider context. Scotland, Wales and Northern Ireland were excluded on the grounds of operating different healthcare systems with different organisational forms. Studies on governance in the NHS have drawn predominantly on semi-structured interviews with board members (Abbott *et al*., 2008; Storey *et al*., 2010; Veronesi and Keasey, 2010, 2011) as well as observations of board meetings. Interviewing executive directors was initially considered for this research but would have been impractical at a time of great organisational change. Many directors were

moving from individual to cluster PCT management functions, with subsequent loss of jobs for some and new roles for others.

Non-participant observation of board meetings was considered but rejected as insufficient to provide the material required to answer the research question. Also the mere presence of the researcher may very well have impacted upon the behaviour of those under study. Existing research (Abbott *et al.,* 2008) demonstrates that the NED role was not confined to board meetings and, indeed, that these public board meetings might be constructed performances, rather than a comprehensive reflection of the NED role in governance (Peck *et al.,* 2004; NHS Confederation, 2005). Shadowing some NEDs to achieve a close look at their work was also considered; however, the part-time nature of the role meant this was not possible due to the widespread geographic locations of the 37 organisations included in this study and NEDs' limited time actually sitting on committees. In addition, the confidential nature of many of the committee workings would preclude it.

The choice of method deemed to get the most potentially valuable understanding of this challenging area of research was therefore to undertake a semi-structured interview with PCT NEDs and Chairs from across England by telephone to gain their views and understanding of their role and contribution to governance. Telephone interviews were judged as giving the greatest opportunity to explore, in depth, the different perceptions and understandings around the NED governance role. Telephone interviewing is now a widely used method of data collection in social research (Sturges and Hanrahan, 2004; Cachia and Millward, 2011; Irvine *et al*., 2013), and can be seen as one way of overcoming interviewee reticence by minimising the demands on time and privacy engendered by much qualitative interviews (Ross *et al.,* 2001; Sturges and Hanrahan, 2004).

NEDs are not employed by the NHS but are public appointments with a time expectation of 2.5 days each month given to the role. Many NEDs found the role took up more than 2.5 days and impacted on their paid work and home life. Mindful of the respondents' limited time I felt that telephone interviews that could be arranged at a time convenient for them (day or evening) would increase the

response rate. The disadvantages of telephone interviews have been considered by Gilbert (2008) among others as missing the nuances and visual cues communicated by body language. However, Novick (2008, cited in Irvine *et al.,* 2012, p.89) questions whether this data loss is necessarily detrimental. In a comparison of telephone and face-to-face interviews, Irvine *et al.* (2012) found that interactions between interviewer and interviewee differed with a greater number of clarification requests from the interviewee in telephone interviews and with less social interaction pre- and post-interview, compared to face-to-face interviews. The authors suggest this meant telephone interviews may have a relatively more 'businesslike' atmosphere, with interviewees more conscious of their role as information providers (Irvine *et al.,* 2012, p.102). As I reflect later, I felt this more businesslike interview was an advantage to me as an insider-researcher.

3.3 Research design

Sampling and recruitment

As highlighted earlier, the data collection took place during a time of rapid change for PCT NEDs. The number of NEDs rapidly decreased as PCTs that were part of a cluster were ordered to operate with a single board and for these arrangements to be in place by December 2011 (DH 2011b). When data collection began in October 2011 there were approximately 650 PCT NEDs. By the end of January 2012 there were 350 NEDs working across 51 PCTs or PCT Clusters (Appointments Commission, 2012, personal communication). Each PCT or cluster was approached to take part in this research. A stratified sample was sought from across England to ensure a balance of urban, rural, large and smaller PCTs as initial pilot work suggested that the experience within one SHA area could be significantly different from another at times, and also vary depending on size or location. PCTs ranged in size from serving populations of about 140,000 up to 1.2 million (Baird *et al.,* 2010). A map showing the 37 different PCTs represented in this study is shown in appendix B (p. 294) accompanied by a list of the respondents from each, date of appointment and a brief description of the PCT, while preserving anonymity (appendix C, p.295).

Using telephone interviews enabled there to be a large sample of PCT NEDs and Chairs participating in the research across England.

As NEDs are not employees of the NHS they do not usually have NHS email accounts and there is no way of contacting them *en masse*. It had been hoped the Appointments Commission, which is responsible for the appointment of PCT NEDs, would assist in contacting NEDs and inviting them to take part in my research, as it had a regular NED e-bulletin. However, the announcement of the abolition of the Appointments Commission meant the organisation was winding down and no longer sending out regular communications.

The research began with London PCTs. The King's Fund (a London-based charity involved in health research and training for NHS board members) contacted the PCT NEDs within its network from across London. From this round I recruited 15 people, representing each of the different London PCT clusters. For other parts of the country my approach was to use the internet to identify different PCTs and whether the PCTs were part of a cluster. I then rang to gain the contact email address of the Chair of the PCT or cluster, emailed with details of the research and asked them to circulate my email to NEDs in their PCT or cluster of PCTs. Some Chairs responded enthusiastically and encouraged their NEDs to respond. In other cases I did not receive an acknowledgement, so I do not know if my request was forwarded to NEDs or not.

Once an email had been received from someone willing to participate, I sent an information letter (appendix D, p.299) and a convenient time was arranged for the interview. These were conducted by telephone, with each interview lasting an average of 45 minutes, although several took an hour or slightly more. Each interview was recorded, with permission.

Twenty-five interviews were carried out between 14 October and 8 December 2011. In 2012 each of the remaining PCT Chairs who had not been contacted were emailed, inviting both them and their NEDs to take part. A further 27 interviews were carried out, concluding on 4 April 2012. In total, 52 interviews with PCT NEDs and Chairs were completed over a five-month period. When I reached 50 interviews I had intended to stop interviewing but was then

contacted by two NEDs from an area where I had had no previous response so I decided to include them in the sample. There was no further contact from potential interviewees after this time.

A breakdown of the age, gender, date of appointment and other characteristics of the NEDs and Chairs interviewed is in shown in table 3.1.

Table 3.1: Characteristics of the sample of 52 NEDs and Chairs

Characteristic	Total: 52 respondents	
Gender	Male 28	**54%**
	female 24	**46%**
Age	30 – 39 years 2	**4%**
	40 – 49 years 9	**17%**
	50 – 59 years 12	**23%**
	60 – 69 years 22	**42%**
	70 – 79 years 1	**2%**
	Not disclosed – 6	**11%**
Length of time as PCT NED	< 2 years 5	**10%**
	2 – 6 years 27	**52%**
	7 – 10 years 20	**38%**
Chair of audit committee	Yes – 7	**13%**
Chair of PCT until 2011	23	**44%**
Current Chair (of Cluster)	17	**33%**
Previous NED role before becoming PCT NED	Yes – 18	**35%**
Currently have other NED roles	Yes – 31	**60%**
	Local Councillor – 7	**13%**

While the majority interviewed had been appointed since the 2006 reforms, all of those appointed before that time would have had to go through a competitive process to be reappointed to the 'new' PCTs in 2006-07. Of the 23 Chairs interviewed, 10 had been appointed before 2006 and then reappointed to the

'new' PCTs in 2006. The others had been appointed in the 2006 wave of appointments or since then, though many had previously been either NEDs or Chairs of other NHS Trusts. The advantage of having a number of very experienced Chairs within the sample was the breadth of knowledge and experience they were able to contribute to understanding the NED role.

Those interviewed were asked the name of their PCT and whilst they were promised the PCT would not be identified in the research, this enabled me to look at board minutes and the PCT website for secondary information regarding the PCT and the particular context within which it operated. I also researched news items, such as in the Heath Service Journal, relevant to the region. I sought broad geographical representation across England, including city and rural PCTs, which I was able to achieve, and my interviewees represented 37 different boards and 26 of the 51 PCT clusters in place by April 2012.

Ethics

The research conformed to the College's ethical guidelines, set out in the College Guidelines on Responsibilities and Procedures for Ethical Review (Birkbeck, 2010) and consent was gained from the School of Management and Organizational Psychology's Ethics Committee. The research abided by the general principles of research ethics: voluntary participation and the right to withdraw at any time, protection of participants' identity, an assessment of potential risks to participants, obtaining informed consent, and doing no harm (Silverman, 2010, p.153). Prior to each interview a participant information sheet was sent by email, detailing issues of confidentiality (appendix D, p. 299). At the beginning of each telephone interview the participant was asked if he or she had read the information, was happy for the interview to be recorded and whether they had any questions regarding the research. None expressed any concerns.

Development of the interview schedule

The review of the literature on the NED role and the research questions informed the development of the interview schedule. These helped explore how individual NEDs understood their role and how they felt able (or unable) to

contribute to the governance of PCTs. These questions covered four broad areas. The first explored how NEDs understood their governance role and factors that might influence this, such as professional background. The second concerned respondents' views about relationships with other members of the board and the roles they undertook both on the board and outside of it. The third topic area explored how as individuals and as groups of NEDs they felt they had contributed to governance in the PCT and factors that either limited or enabled this contribution. The fourth and final area asked about their current role, in light of the changes brought about by the proposed abolition of PCTs and requirement for PCTs to cluster with shared management arrangements (DH 2010b). The interviews were designed to be semi-structured and allowed the researcher to respond flexibly to the responses received. The interview questions can be found in appendix E (p.301).

Two pilot interviews were carried out, with NEDs in my own PCT whom I knew I would not be approaching for the final interviews. They gave me feedback on the interview process and how this could be improved, such as the wording of a couple of the questions and the order I asked them. This pilot involving drawing upon such expertise proved extremely useful in informing the design of the structured telephone-based interviews.

3.4 Analysing the data

This section details the analysis of the data in line with Braun and Clarke's (2006) approach to thematic analysis. This is described as 'a method for identifying, analysing and reporting patterns (themes) within data' (Braun and Clarke, 2006, p.6). The reason for adopting their approach to analysis is that it is theoretically flexible and able to be used with constructivist and experiential frameworks, although Braun and Clarke stress the need to make explicit the underlying ontological and epistemological assumptions when approaching analysis. The critical realist approach of this study has already been discussed. It acknowledges the reality of the actors' meaning and intentions but also acknowledges the ways those meanings are influenced by the broader social context and system elements such as institutions and power. The approach of

Braun and Clarke (2006) to data analysis fits well with the adaptive theory approach of Layder (2008).

Braun and Clarke suggest a six-stage process of analysis, shown in table 3.2. While this might seem like a linear process, the first few stages can be cyclical, with the researcher continually reflecting on the data, the codes being generated, relevant literature and then refining initial codes. The analytical process is described in four sections, following Braun and Clarke's different phases. These are 1) Gaining familiarity with the data and generating initial codes, 2) Searching for themes, 3) Reviewing themes and then, 4) Finalising themes and presenting results.

Table 3.2: Phases of thematic analysis (Braun and Clarke, 2006, p.87)

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Gaining familiarity with the data and generating initial codes

The interview recordings were transcribed professionally. I then checked each for accuracy, listening to the recording and making additional notes where necessary, such as significant pauses or hesitations. This also enabled me to gain familiarity with the transcripts. As this was done while the interviews were continuing, it also enabled me to reflect on my own role in the process, such as where I might have stepped in too quickly to affirm a response rather than giving prompts for further elaboration. I was then able to adjust my performance for subsequent interviews. I was also able to reflect on some initial thoughts arising from the data. I kept a reflective journal where I noted these, to potentially return to as data collection and analysis progressed.

When all the interviews had been completed I read all of the transcripts to gain an overview of the material, with notes made on recurrent issues and the development of ideas. The next stage was to develop some provisional codes. Some codes were derived from theoretical ideas independent of my particular project and informed by my prior reading. This deductive approach meant looking for links in the data to concepts I had already identified as of interest, such as social identification with a particular group or different sources of power. Other codes arose inductively from the data. Braun and Clarke describe a code as 'a word or brief phrase that captures the essence of why you think a particular bit of data may be useful' (2013, p.207). Thus coding meant highlighting key phrases in the transcripts. These initial codes were quite personal, as I was a sole researcher and so met my requirements rather than needing to be useful to anyone else. I used NVIVO software to help with the management of the data and to code each interview, line by line. The use of NVIVO allowed the comparison of data and to make links to different between codes

An example of the initial coding of my data is shown in table 3.2 below, using an excerpt from one of the interviews.

Table 3.3: Example of coding: interview transcript 20

Data extract	Initial codes
I came in and I was chair of the audit committee. I was the only one with a strong financial background of the people on the board. And we were an amalgamation of three PCTs, two of which were in deficit, significant deficit. And when I started the one discussion I did, I had actually this in the first week following us starting, the first week in October. And I said to the chair you know, what do you want	Audit Chair Financial background Organisational context: Merged PCT in deficit Influence of Chair Assigned role

from me, and he said above all else I want you to crawl all over the finances of this organisation because I do not want... he'd been a chair of the two that had been in deficit; I don't want to be in that position ever again. So that's what I did and we didn't if you like, and at time I think my challenge was key to ensuring that because I've stopped one or two, what I would describe as flights of fancy being included in the financial plans of the organisation. So, so there's very specifics stuff there, but I hopefully also most of the time being seen as being a constructive support and a provider of experience from another field. And I got asked on a lot of additional ad-hoc working groups and the like so presumably people weren't just trying to keep things far away from me as possible.	Greater operational involvement ensuring organisation in financial balance blocked plans Using professional knowledge to judge executive plans supporting management providing expert knowledge Invited on to working groups (more operational involvement?) Trusted with information (Boundaries between operational and governance roles?)

The preliminary coding categories were further developed as the analysis continued. This involved an iterative process, moving backwards and forwards between the transcripts and codes. I also began noting some provisional interpretations and areas of interest to explore further, such as the boundaries between operational involvement by a NED and their governance role, as in the example above. The process of coding is part of analysis and of organising the data into meaningful groups.

One aspect of interest for this study was the influence of different identities on role, using insights from social identity theory. Language is a common indicator of self-categorisation. Identification with a social group can be assessed by the

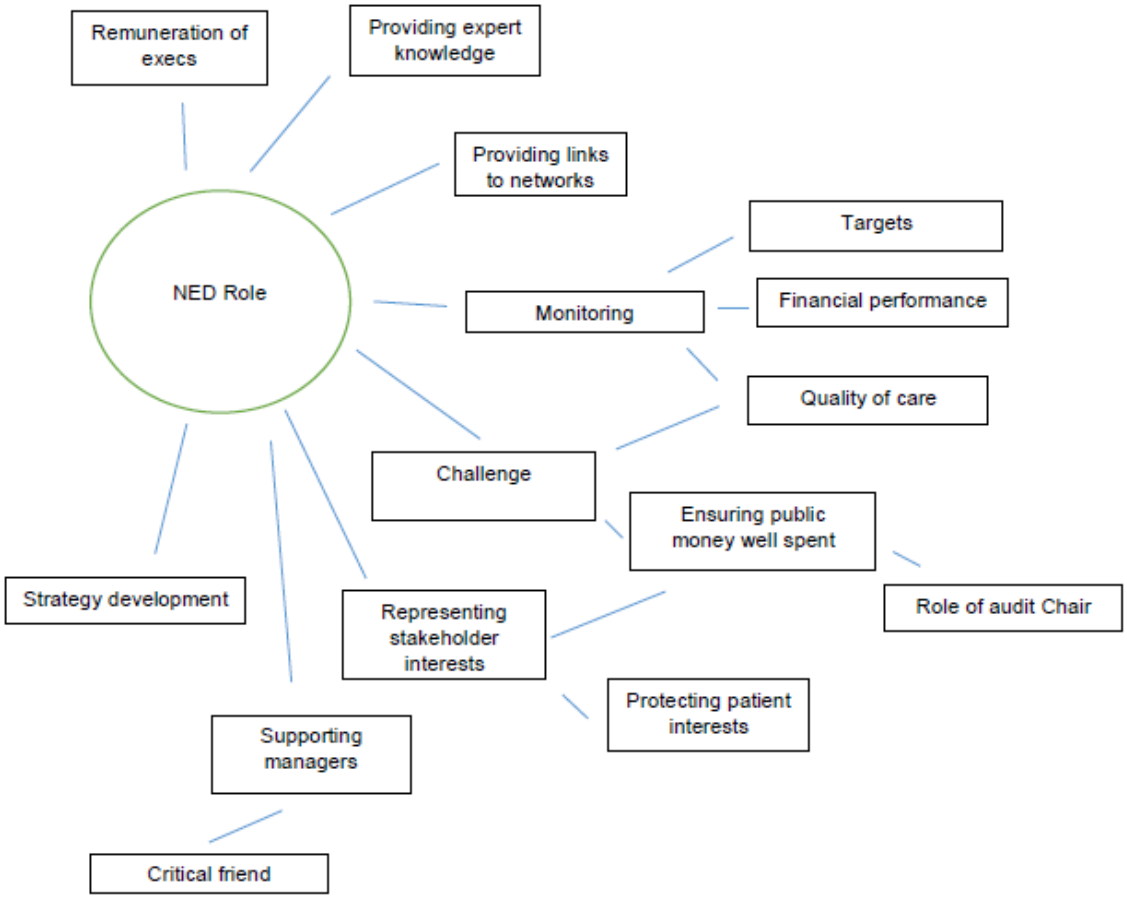
use of the plural first person (we and us), along with factors such as direct references to being part of a group and those who are outside the group (Pennington, 2000, p.107).

Analysis of the interview data to assess the salience of an identity involved assessing whether the respondent predominantly used the first person, singular and plural, and also whether in general they spoke of themselves as part of a group such as the organisation, a specific part of it (such as the board) or saw themselves as quite distinct from it. While some of the lines of inquiry in the interviews were specifically personal, others explored more widely the contribution of NEDs or the work of the board. Some respondents though still predominantly used the first person singular and rarely, if at all, did their accounts use the third person.

Searching for themes

Some themes were theoretical ideas identified from the literature, such as the salience of different identities and different sources and use of power, while others arose from analysis of the data and involved the active searching for patterns and themes. The judgement of the researcher as to what constitutes a theme is discussed by Braun and Clarke, who consider that rather than being dependent on some quantifiable measure, such as frequency of occurrence in the data, it depends on whether the theme captures an important element relevant to the overall research questions (2006, p. 82). An initial thematic map regarding the NED role is shown in figure 3.1.

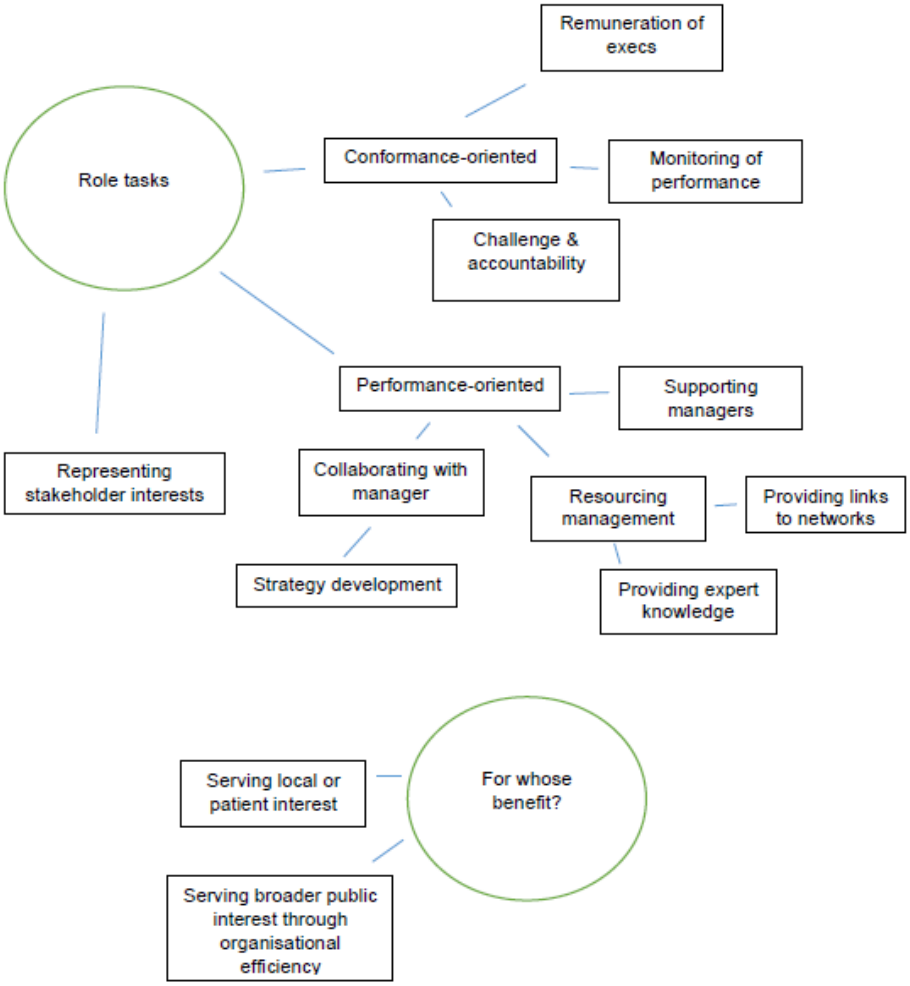
Figure 3.1: Initial codes and thematic map. The NED role



My first attempt at identifying themes, I later recognised, treated the accounts given by respondents as real events, rather than treating them as more performative accounts, that is, how NEDs and Chairs were positioning themselves in these accounts of their role and contribution. A critical realist approach includes a 'hermeneutic of suspicion' (Josselson, 2004) and I later needed to revisit my initial coding and the themes generated as well as developing more sociological interpretations. During this process of revisiting the data and initial codes I realised, for example, that what I had first identified as enablers of the role, such as local knowledge and relationships with other stakeholders, were sources of power for the NED. Themes initially coded as constraints of the NED role, such as the role of the Strategic Health Authority, were then re-examined to consider the different sources of power and how these were utilised within this hierarchical arrangement of accountability. I also realised that although some NEDs saw part of their role as representing patient

interests on the board, while this was not articulated by others, the use of language showed different identification with different groups, such as local people or the organisation. The analysis of data was accompanied by further reading around social identification and self-categorisation theories, which further helped with analysis of data and the development of a typology of different kinds of NEDs – those representing a broader public interest or a local interest (or neither). The framework provided by Tricker (1994, 2015) of performance-oriented and conformance-oriented governance roles also helped in providing codes to organise the data. More developed governance themes are shown in 3.2.

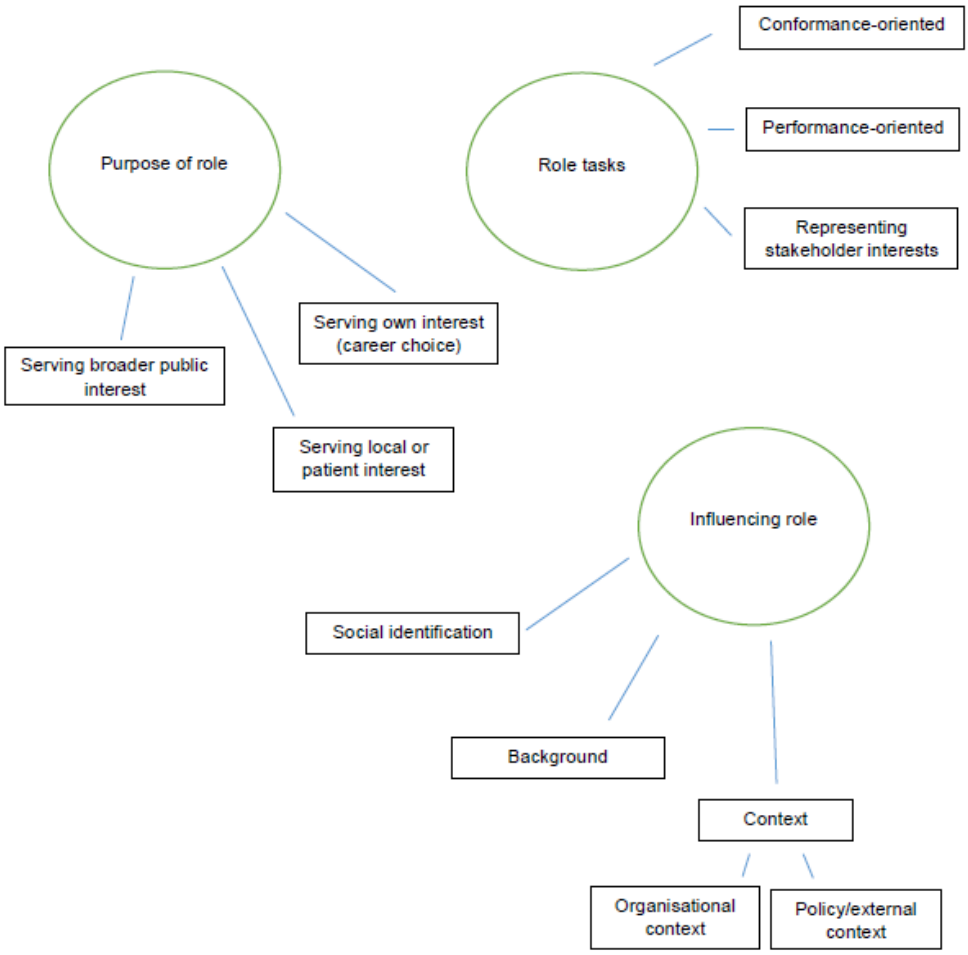
Figure 3.2: Developing the thematic map. The NED role



Reviewing themes

The fourth phase suggested by Braun and Clarke (2006) is to review the themes, to discard those that may not have enough data to support them, to merge others or separate broader themes. They then suggest a re-read of the entire data set to see how the thematic map fits or needs to be revised. This is to see if the themes work and also to code any additional data within themes that have been missed in earlier stages (p.91). As discussed above, I revised my original themes to take a more critical and sociological perspective. Not all of the data fitted into themes. The timing of the interviews meant that for many NEDs, myself included, a key interest was the governance arrangements of CCGs. I had asked about this and many respondents were keen to give me their views. Several months after the abolition of the PCTs such views seemed to have little relevance, except what it revealed about aspects of the governance role respondents saw as important, such as dealing with conflicts of interest and the importance of providing challenge. After several revisions of initial codes and themes I then created a new project in NVIVO and coded all interviews using the new thematic map. The revised thematic map for the NED governance role is shown in figure 3.3. These themes are discussed in Chapter Four.

Figure 3.3: Final thematic map, showing final three main themes for the NED governance role



Phase five of Braun and Clarke's (2006) steps in thematic analysis involves further refinement of the themes and analysis of the data within them. These form the structure of the subsequent chapters.

As a NED within a PCT I recognised that it is impossible to completely eliminate researcher bias. However, I wanted to ensure that my own experience as a NED had not led me to ignore some of the findings and miss possible themes. Two research colleagues, with no prior knowledge of PCTs or governance, independently read a selection of transcripts and identified key themes. These were compared to those already generated to see if there were areas that had been overlooked. No major omissions were identified though the conversations were helpful, as they highlighted areas that seemed more significant to an outsider and which I might have played down.

3.5 Quality assurance

Characteristics of qualitative research include that it is reflexive in design and acknowledged as open to researcher-bias (Bluhm *et al.,* 2010). That is, it is accepted that the qualitative researcher's subjectivity, informed by their experiences, will influences the data throughout the research process. The research findings are co-created by the respondent and the interviewee, with the researcher playing an active role in constructing the findings, rather than as a transparent conduit of 'facts' (Yanow, 2006a, p.80). My approach, understanding and analysis of the data will differ from other researchers. A hallmark, therefore, of good qualitative research is its commitment to reflexivity, involving critical reflection on the research process and one's own position in the research (Pratt, 2009). Two forms of reflexivity, functional and personal, are identified by Wilkinson (1988). The former considers how the choice of approach may have influenced the research, while personal reflexivity involves the researcher actively reflecting on how s/he has may have shaped the data. For Bansal and Corley (2011), key criteria for good qualitative research are that the researcher's voice must be visible, acknowledging the role the researcher plays in the research outcomes (p. 236). In this next section I present a brief biography, followed by some reflections on being an insider-researcher.

Reflexivity and the researcher

I recognise that my own role as an 'insider', that is a member of the community I am researching, will have influenced my approach to this study and indeed may very well have impacted upon the reactions of others towards me when participating in this research. I originally trained as a nurse, later worked in the voluntary sector and while working for a children's charity undertook an MA in Community Development. It was while studying for the MA that I applied for the role of a NED within a PCT when these were created across England in 2002. I applied as I thought I may be able to use my experience of community development to help the PCT address longstanding issues such as health inequalities and improve services close to my heart, such as maternity and children's services. I was appointed after a competitive process and quickly

gained an interest in governance and the corporate role of the board, rather than purely seeing my role as a representative one. I was reappointed as a PCT NED in 2006 and later became Chair of the community services. When my PCT was clustered with others in 2010 I was appointed to the board of the cluster PCT after a further competitive process. I was therefore a PCT NED for the entire 11 years of their existence, and the desire to undertake this research arose from my personal experience. The data collection for this study began shortly after I had joined a cluster board and in the final 18 months of PCTs. The writing up of the results began during this time and continued after March 2013 and the abolition of PCTs.

Being an insider researcher

The interviews were undertaken at a time of considerable change for all PCTs, as many moved to shared management structures prior to their abolition and as they also began transferring responsibilities to new organisations. I consider my status as a NED assisted me in gaining access to other NEDs. In many of the interviews people expressed their desire to help a fellow NED and also their delight that someone was 'telling our story'. Leblanc and Schwartz (2007) note the difficulty of studying the 'what and how' of a board of directors, including issues of access and confidentiality. They found that the standing of the researcher can help with access to elites, whether as a fellow-member or of similar social standing, and this was my experience.

As a PCT NED myself I was a member of the community being interviewed. The advantage of this insider knowledge was that I already had an understanding of the phenomena (PCT governance) under investigation. I therefore did not have the same learning needs of interviewers who need to 'get up to speed' with the subject area and was better able to pick up on the nuances and different interpretations offered. Other advantages of being an insider researcher includes acceptance by the group, with participants more willing to share their experiences because there is an assumption of shared understanding (Dwyer and Buckle, 2009).

The disadvantages of being a member of the group as an insider researcher include the holding of particular assumptions by the interviewer, which may mean less receptiveness to views which differ (Johnson and Rowlands, 2012) and possibly prevent the participant from fully articulating his or her own point of view or confusing the issue with their own views (Talmage, 2012, p.300). I felt the greater anonymity provided by telephone interviews was an unexpected advantage in this regard. I have attended various NED conferences and may have possibly met those I interviewed, and although I did not recognise any of the names (nor they mine) a face-to-face meeting might have provoked recollection on both sides. I wanted to hear the individual's account and felt it possible that if we were in the same room then the shared experiences of being a NED could lead to more of a discussion, with people wanting to see if I shared their views or had had similar experiences in my PCT.

This did occur within a couple of interviews and I found that the telephone interview enabled me to not respond directly but to reflect questions back to them. If it had been a face-to-face interview I think this would have been more difficult without appearing aloof and I might have found myself more drawn into giving my views.

This is not to say that my role did not influence the interview, as it probably did. I felt people were more open to me because they thought I would understand their view. Rather than objectivity, Gubrium & Holstein (2012) talk of active subjectivity: respondents help to 'discern and designate the recognisable and orderly features of the experience under consideration' (p.33). The researcher is an active partner and co-producer in this construction, with the participant modifying their responses in the exchange of questions and answers. Researchers are able to identify and name other human actions as we are human ourselves (Yanow, 2006a, p.75).

The stake an interviewer has in the subject and how they can encourage a respondent by strongly aligning with their account through verbal affirmation is highlighted by Potter and Hepburn (2012). They highlight that the active role of the interviewer in framing the questions needs to be made explicit where

necessary (p.568). This has been adhered to in the presentation of the results (Chapters Four to Seven).

I was aware that as a member of the NED community I was keen to find that NEDs had made a significant contribution to governance, so made a conscious decision to look for data that would disprove this. A deliberate reflexive approach was adopted, with an awareness of my own biases and perspectives. A diary with written reflections on my role in the research and possible influences on the research process was maintained throughout this research. The passage of time also helped, with the writing up of this study taking place after the abolition of PCTs and when I was no longer a NED, enabling me to take a more critical perspective of the NED role.

Further methods of quality assurance

Different research approaches use different criteria to judge their quality, informed by the underlying theoretical assumptions. Terms used in quantitative approaches like generalisability, objectivity and reliability, linked to a desire for replicability, are not considered appropriate for qualitative research (Tracy, 2010, p. 838). The approach of this study is critical-realist, opposing the positivist view that there is a real 'reality' that can be accessed. Rather, it recognises that any truth can only be imperfectly known. So instead of seeking to prove 'quality', Tracy (2010) suggests eight criteria of quality within qualitative research, which are 1) a worthy topic, 2) rich rigour, 3) sincerity, 4) credibility, 5) resonance, 6) significant contribution, 7) ethics and 8) meaningful coherence. She then suggests the means and practices by which such goals maybe achieved. The previous chapter attempts to set out why the current topic is a worthy one to address. The contribution of this research and its resonance, or impact (criteria 5 and 6) is considered in Chapter Eight. The other criteria and the methods used to address them in this study are now explored in greater detail.

Rich rigour

For Tracy, high-quality qualitative research should be marked by a richness of description and explanation as well as rigour. This can be judged by the care and practice of data collection and analysis (2010, p. 841). Questions can be asked as to how much data is enough. I gathered 52 interviews with NEDs/Chairs and three with key informants, gaining more than 45 hours of recordings. This chapter has set out details of how data collection was approached and also tried to give a transparent account of how the data was analysed.

I have attempted in my approach to the research, analysis and the presentation of the findings to do so in a way that is faithful to the understandings of those who experience the phenomena first-hand, that the 'results are representative of the interpretations of those experiencing the phenomenon under study' (Shah and Corley, 2006, p.1823).

Sincerity

This relates to notions of authenticity and genuineness (p. 841) and includes the practice of self-reflexivity. 'Reflexivity' recognises the influence of self upon the research, with an awareness and consideration of its impact (Schwartz-Shea, 2006, p.102). A widely-recognised practice within interpretive-qualitative research is the keeping of a reflexive diary, deliberately reflecting on and theorising about the impact of self on the research process. I was aware of self throughout the research process, in the way I approached the design of the questions, and also how answers were filtered through my own experience as a PCT NED and the significance I attached to the data (Talmage, 2012, p.298). A reflexive account and a personal reflection on the process have been provided. Sincerity also relates to transparency and honesty about the research process, including its challenges. This is included in the final reflection.

Credibility

This encapsulates the need for the research to be able to be trusted, namely that the approach has been systematic, transparent and ethical. Approaches to achieving this include thick description and multivocality (Tracy, 2010, p. 843)

'Thick description' was a term initially used by a researcher, Gilbert Ryle, but developed further by Clifford Geertz (1973). The oft-quoted example is of a wink, where 'thin description' might simply refer to the contraction of the right eyelid. However, 'thick description' would encompass the meaning of the 'wink' such as its conspiratorial nature (Geertz, 1973, p.7). To provide thick description means the researcher provides enough details of the context as well as sufficient of the respondent's own words that the reader can assess whether they do indeed support the themes the researcher claims. The inclusion of the respondents' own words enables the reader to judge the interpretation of the researcher and also bring the participants view to life. This research will therefore include a number of direct quotes from interviewees throughout the data results chapters.

Multivocality means including multiple and varied voices and attending to divergent viewpoints as well as those of the majority. I have tried to adhere to this in the presentation of the results. Tracy suggests this multivocality can also be achieved through collaboration with participants, as part of the research process, including through member reflections. This is a term preferred by Tracy to member checks, which goes beyond seeing whether the research got it right to providing opportunities for 'collaboration and reflexive elaboration' (2010, p. 844). At the end of the research process the findings of this study were presented and discussed with two former PCT Chairs. The significance of identity as an influence on the role was discussed further with former NHS NEDs during the process of revisions to this thesis. Identifying with stakeholders and acting in a way to defend their interests had a particular resonance, and talking this aspect through with them helped me to reflect further on this aspect of the role.

Ethical

Ethical research encompasses a variety of practices including the ethic procedures used to safeguard participants, such as discussed earlier in this chapter, as well as situational and relational ethics. These require the researcher to reflect on his or her actions and their consequences for others, including the impact of the findings on others. A reflexive approach was maintained throughout the study, including the writing up of the data. I was mindful of this in how I presented the data, not only ensuring anonymity but also how it might be interpreted by the reader.

Meaningful coherence

Tracy (2010, p. 848) describes this criterion as one where there is coherence between research design, data collection and analysis with the theoretical framework and research goals. As a new researcher this study has been a steep learning process, requiring much deliberation and reflection on my theoretical assumptions and research design. The lessons learnt will I hope stand me in good stead for future research.

Chapter conclusions

This chapter has described the research method and philosophical approach of this research. It has presented in detail how data was accessed and interviews conducted. It has included a reflective element on how I approached the study, recognising my own membership of the community I am studying. The chapter has sought to make explicit the approach taken in a systematic, transparent and ethical way that it may be found to be 'trustworthy'.

The next four chapters present the more detailed findings from the research.

Where excerpts from interviews are included a number identifies the respondent and whether they were a NED or Chair. The PCT is referred to by an alphabetical letter. Appendix B (p.294) sets outs the broad location of PCTs, without identifying them, Appendix C (p.295) presents further details of respondents and PCTs. This research interviewed 23 PCT Chairs, 17 who were

now Chairs of clusters of PCTs, while the others became vice-chairs of clusters. Two of the Chairs interviewed had only recently stepped up to the Chair role, owing to the departure of the current Chair. Owing to the short time scales before PCT abolition these posts did not go out for open appointment, but rather an experienced NED was asked to step up to the Chair role. These two Chairs had been NEDs for several years, and in their reports referred more to the NED role rather than the Chair, so are included in the NED analysis except when they specifically talked about the role of the Chair. Chapter Seven looks particularly at the role of the Chair, as distinct from the role of the NED.

Chapter Four: Perspectives and influences on NED roles

This chapter is the first to present empirical data from interviews with PCT NEDs and Chairs who took part in the current study. It sets out different understandings of the NED role identified from analysis of the data before exploring different influences on how the role was perceived by the respondents. This includes considering how the strength of identification with a particular group identity might influence the role. The final section integrates these insights and other factors, such as the influence of background, to identify three different types of NEDs.

4.1 Understandings of the PCT NED role

NEDs within the private sector have a fundamental duty to protect shareholders' and stakeholders' rights. This gives rise to a range of conformance-oriented roles in monitoring executive performance, providing independent judgement and accountability to stakeholders. A further range of performance-oriented roles see the NEDs working more collaboratively with executives in strategy formation and contributing wider business knowledge and experience (Tricker, 2015).

Within the NHS the role of the board and NEDs draws heavily from corporate governance theories and literature. Existing studies have found a lack of clarity around the NHS NED role (Storey *et al*., 2010) and have questioned the influence a NED may have on governance (Veronesi and Keasey, 2010, 2012). Against this background a fundamental question for this research was to explore how this practice of corporate governance may be different within the public sector, drawing on the experience of PCT NEDs.

NEDs' roles: exploring understandings

The PCT NEDs and Chairs interviewed for this research were asked how they understood the NED role. A later chapter considers the Chair role and examines

different approaches by Chairs to the role of the NED. This chapter considers the NED role from their perspective. Analysis of the data showed the dominant theme to be the holding to account of executive directors for organisational performance. Other roles included supporting and collaborating with managers, and providing resources as well as representing stakeholder interests. These roles are shown in table 4.1. The left column shows the roles identified from analysis of the data along with the percentage of accounts where NEDs saw this as part of their role. The second column maps the role across to the 2006 guidance (Appointments Commission, 2006) on the PCT NED role, produced when the PCTs were restructured and there was open competition to all PCT NED and Chair roles.

Table 4.1: The governance role of PCT NEDs. Source: Compiled by the author

Codes derived from data % of respondents identifying this as a major aspect of role	**Maps to guidance on roles and responsibilities of PCT NEDs (Appointments Commission, 2006)**
Ensuring compliance (81%)	Monitor the performance of the executive team in meeting the agreed goals and improvement targets Ensure that financial controls and systems of risk management are robust
Contributing to strategy (42%) Supporting managers (23%)	Contribute to the development of strategic plans to enable the PCT to fulfil its leadership responsibilities for healthcare of the local community
Representing local/patient stakeholder interests (45%)	To have a 'high-level commitment to patients, carers and community'
Contributing skills & knowledge (100%)	The guidance begins with the statement 'your role is to use your skills and your personal experience as a member of your community'

From NEDs' descriptions of their role there would appear to be a great conformity with the guidance provided. However, there was more emphasis on

representing stakeholders, which proved to be a strong theme in this study, than there was in the published roles and responsibilities. These governance roles were not mutually exclusive so, for example, while some NEDs saw themselves as representing certain interests or providing resources through the contribution of particular knowledge or skills, they also played particular roles vis-à-vis management, whether one of ensuring their compliance or a more collaborative relationship.

Ensuring compliance

For many NEDs (81%) the dominant aspect of their role was one of monitoring executives and holding them to account for their actions. This reflects the emphasis in the guidance for the role (Appointments Commission, 2006). This conformance-oriented aspect of the role was internally-facing, concerned with present performance (Tricker, 2015). It involved the scrutinising of executive reports and ensuring the PCT met its performance indicators, as set by the Department of Health each year.

A key theme from accounts was the NED role of providing 'challenge' to executive directors. As this London audit chair explained when describing his role:

> *(It) was to hold the executive to account for what they were doing and when I say hold to account, that's not meant to be a nasty phrase but it's meant to be constructive, supportive challenge.* NED 11, PCT L9.

In PCTs that were in financial deficit – the situation in five of the PCTs represented – the monitoring and challenge aspects of the role were particularly prominent.

There was an emphasis in accounts on 'second-order' functions of finance, corporate governance and administration, confirming the findings of Abbott *et al.* (2008) in their earlier study of PCT boards. This may reflect the current context, one where NHS finances had a high political and media profile, and also because clinical matters were within the remit of the professional executive committee. However, the quality of commissioned services was a concern,

though was a less-dominant theme. It was more prominent in the accounts of those from non-business backgrounds, as seen in this excerpt from a NED in Central England with a health research background:

> *I suppose I thought of it in terms of challenging executive colleagues in a supportive way to ensure that the money was being appropriately managed but importantly that, that the quality was… was being delivered.* NED 41, PCT I.

While the monitoring role was the dominant one identified from analysis, respondents also identified a strategic role. This appeared less frequently (42%) in accounts and as a weaker theme in analysis. The dominant emphasis of the strategic role was the scrutinising of strategic proposals presented to the board, so still within the control aspect of the role rather than a service aspect of strategic participation (Minichilli *et al*., 2009). The theme of challenge remained a dominant one in this scrutiny of strategy, as in this account from a NED in South-east England with a voluntary sector background:

> *It was to provide a strategic overview to deal with, stand back and look at proposals that came into the board and give a fresh view and also to provide constructive challenge.* NED 34, PCT E.

This emphasis on the compliance-oriented role reflects an agency perspective, where NEDs have a primary role in the monitoring of management to ensure self-interest is kept in check (Daily *et al.,* 2003).

Collaborating with and supporting managers

However, for some NEDs (23%) there was less emphasis on the monitoring aspect of the role and more on the collaborative aspects of working alongside managers. The major influence on how NEDs saw this relationship appeared to be the professional background of the NED, with this closer identification with managers coming from those who either had a professional background within the NHS or a similar managerial role before retirement. The influence of background on role is explored further later. This more-collaborative approach

is seen here from a NED in a London PCT, who had recently retired from a senior executive position within a major UK Bank:

> *Holding to account, yes, you know, we ask questions and do our non-executive bit but I think our, I think our contribution is in the non-formal board bits of being there and just bringing outside experience and support of a standing board.* NED 17, PCT L7.

Another NED from a PCT in the South-east of England, a recently retired senior executive position in a global company, also saw his role as combining support and challenge:

> *And I think as far as NEDs are concerned we are challengers, we are, that dreadful phrase, critical friend. That comes from the school but I think we are critical friends and above all we are supportive and I think generally it works well, the relationship*. NED 31, PCT F.

Stewardship theory counters the distrust inherent in agency theory, seeing managers rather as stewards acting for the good of the organisation (Davis *et al.*, 1997). The stewardship and agency perspectives are not mutually exclusive (Sundamurthy and Lewis, 2003) and can be held in tension, which NEDs in this study appeared able to do and is an aspect of the role examined further later.

Representing stakeholder interests

Almost half of the respondents (45%) clearly identified themselves as representing particular local stakeholders such as patients or the local community, as in this example from a NED in the North of England who was not working at the time of her appointment in 2002 but had childcare responsibilities:

> *I was going to put a community voice into the board, obviously look at governance and things but there was a… you know that I would be the generic patient and certainly that is the way I've dealt with my role a lot of the time in fact.* NED 15, PCT W.

A retired accountant, later appointed to the same PCT, also saw a representative role:

> *I suppose it was the old fashioned, that sounds negative, it's not meant to be, of representing the people of (…)* T20*,* PCT W.

The reference to 'old fashioned' refers to the role of the NED at the creation of PCTs in 2002 when they did have more of a community representative role, though this NED was not appointed until 2006. It could have been expected that NEDs who saw a representative element to the role would have been appointed at the creation of PCTs in 2002, when the idea of a community representative had guided the conception of the PCT board and its recruitment. However, as many had been appointed to PCTs since 2006, when a revised role specification was developed, this perception of the role appears to have been influenced by other factors, such as background or a strong identification with a particular stakeholder group. This is explored further later this chapter.

Identification with stakeholders does not proscribe the relationship the NED may have with management, such as acting within a monitoring or collaborative role. For some NEDs there was what might be seen as an agency perspective of distrust, with the NED role seen as ensuring stakeholder needs are defended against the potentially dominant interests of the organisation, as for this NED from a health research background in a PCT in the South-east of England:

> *I think my PCT was quite good, but even so it was often quite a challenge to get the patient-centred issues, the patient-centred focus, in our strategy and in our board meetings… But a lot of board business did actually neglect, and conflict with my interests and concerns for actual, sort of, patients.* NED 46, PCT E.

However, when examining the contribution of NEDs, the route to achieving the promotion of particular interests reflected a more collaborative relationship rather than an adversarial or defensive one. NEDs worked closely with executive directors in promoting particular interests, such as the quality of patient services.

Contributing resources

Across all accounts NEDs saw part of their role as contributing specific knowledge to benefit the board and the organisation. This might be specific to the voluntary sector or social care, but business skills and knowledge brought from the private sector were considered by these respondents to be particularly valued, as for this NED, a former finance director, now on the board of a PCT in the North-east of England:

> *The other thing was I had had private sector experience so there was part, it was in effect to just give some sort of counterbalance or counterweight to people that had had perhaps only public sector experience.* NED 33, PCT P.

For another NED in a Central England PCT, with a consultancy background working with local authorities, he identified his contribution as:

> *I suppose it's… financial skills strategy, projects, I've done a lot of projects in my time. And a good sort of organisational understanding because I've managed and led organisations in my career so you know understanding what makes a difference if you like in turnaround.* NED 42, PCT J.

The contribution of specific skills and knowledge saw NEDs move into more operational roles but did not appear to cause them any concerns with regard to possible conflict with the monitoring role. These tensions between a governance role and what might be seen as a more managerial one were posed by Cornforth (2003) as a particular challenge for public sector governance but appeared not to pose a problem for NEDs although, as will be considered later, were a concern for some Chairs.

Section summary

This section considered how NEDs presented their role to me as a researcher. Subsequent chapters will explore in greater depth the different areas of contribution and give rise to a wider range of roles than those articulated. Here,

set within a particular time of great change within the health service, NEDs emphasised their conformance-oriented role, involving the monitoring of performance and with an emphasis on providing challenge to executives. Performance-oriented roles included providing skills and knowledge as a resource for the board and organisation. Roles also identified but mentioned less frequently were in supporting executive directors and representing stakeholder interests. The following chapters examine the contribution made in those roles, identify additional roles, and consider the influence of the organisational and external context on NEDs' roles. While context is one important influence on the role, the rest of this chapter will examine other influencing factors.

4.2 Influencing the role

A wide range of factors can influence the governance role of NEDs. Those identified in analysis and to be examined in this section include NEDs' professional background, experience of other NED roles and the motivation to take up a NED role. A strong motivating factor was one of public service, to be discussed later, but some NEDs had different or additional reasons for applying for the role.

Professional background and role

An identification with a professional role held either before or while a board member emerged from analysis as one influence on how the role was understood. The professional backgrounds of PCT NEDs in this study vary, but lean towards the private sector, encompassing those from accountancy and consultancy backgrounds. The number of NEDs from different professional backgrounds is shown in table 4.2.

Table 4.2: Professional background of respondents.

Background	Total: 31 NEDs
Senior positions within the private sector	7 (23%)
Accountants	5 (16%)
Academic/researcher	4 (13%)
Local Authority	4 (13%)
NHS	3 (10%)
Other (including voluntary sector, consultancy)	8 (26%)

NEDs with a business or accountancy background emphasised the value of the skills and knowledge they contributed. Able to provide resources perceived as sometimes lacking in the PCT, their knowledge and experience also enabled them to undertake the scrutiny of performance. This NED in a PCT in the North-east of England described her contribution:

> *I think it's been on the financial side, being, because I'm a chartered accountant, I've got a good knowledge of what auditors are supposed to do, how internal audit works. So particularly on the audit committee I think I've been able to make a difference.* NED 44, PCT Q.

All those NEDs in this study with accountancy backgrounds served on the audit committee and considered their role to have had a particular focus on risk and assurance.

The impact of professional background on role can also be seen in the accounts of two NEDs who were researchers. Their interpretations of their role on the PCT board were strongly linked to their research interests. So, for example, a researcher in public health, with a particular interest in shared decision-making, saw her role as standing up for patients and ensuring patient involvement,

whereas another health researcher with an interest in quality, a NED in a PCT in Central England saw her role and contribution as reflecting that interest:

> *I think I brought about quite a few changes in relation to how, the organisation looks at… particularly at board level and subcommittee level at quality, so I became chair of… what was then the healthcare governance committee and really changed that quite radically so we now have a quality and patient safety committee*. NED 41, PCT I.

For NEDs from third-sector and local-authority backgrounds, the role had greater focus on the wider community rather than on patients, such as improving the health status of the local population and reducing health inequalities. An important aspect of the role appeared to be encouraging a citizen-responsive organisation, such as ensuring the organisation widely consulted on service change. This London PCT NED, with a local authority background, discussed a large consultation held regarding future services at nearby hospitals:

> *We made a real difference because we talked about it a lot in the, in the board meetings and challenged a lot because we did feel very much that there was a, how can I put it, that, that, people fell into a very much into a clinical… frame of mind where we did feel very strongly that they weren't necessarily thinking of the best ways to find out what the public thought of these things.* NED 3, PCT L5.

While PCTs were legally obliged to consult on proposed service changes some NEDs saw a particular role in ensuring that this was done well, with the findings influencing the board's decisions.

An NHS background

Some of the most interesting findings in considering the influence of background on role arose from the accounts of the three NEDs who had had a previous managerial career within the NHS. This gave them a different perspective of the role compared to other NEDs. Close identification with the executive role and the pressure they were under from the SHA, led a former

NHS finance director in a South-east England PCT to see his role as:

> *Giving, trying to help the execs, give them some cover really for where they were doing things that they needed, shall we say, a different type of support for*. NED 35, PCT F.

Two other former NHS employees gave a more negative view of the NED role. For a former NHS Chief Executive the NED role was '*overrated'*, later saying, *'I've moved beyond NEDs and their role because I don't think they had one, or it's diminishing all the time'* (NED 18, PCT L1). A similar 'anti-NED' view was expressed by a former NHS accountant who also felt the NED role to have limited impact, with executive directors having a low regard for the NED role.

The limitations of the role for both men appeared to be the lack of influence the NED was able to exercise. However, while they were negative about the NED role in general, both identified where they personally had made a positive contribution. For the former accountant this was through chairing the audit committee, where he expressed no difficulty in holding the executive to account. The former Chief Executive identified a role for himself in contributing knowledge and experience, with his background giving him credibility with the executives. Their accounts give a contradictory picture of a NED role in general having had little influence, yet they consider themselves to have had personal influence that arose from both personal knowledge and credibility but also from greater access to the Chief Executive than other NEDs.

Other NED roles

More than half (60%) of NEDs and Chairs interviewed had or currently held a NED role outside of the NHS. This gave an understanding of what were perceived as some of the key aspects of the PCT role such as monitoring of executives, risk management and ensuring probity. The differences between the sectors were also highlighted. The size and complexity of the NHS was one aspect, but the dominant difference was the constraints of working within a centralised system led by the Department of Health. A Chair from a PCT in the

North-west of England, who had previously been a NED in the PCT, compared his experience to his private sector NED experience:

> *I think it's been less… less satisfying in one sense and that is I think I had expected the board to be more like a private sector board where more substantive decisions were made…. In practice I think in the NHS the management is driven to get on with managing the business under strong steers from the Department of Health and from the strategic health authorities to whom the executive side are also accountable and the boards after the initial development of strategy have, have been places where we've been receiving information and approving things that have been pretty well already decided.* Chair 12, PCT R.

The NED role was not only felt to be limited in terms of power to influence when compared to other NED roles but also to roles such as a local authority councillor or as trustee of a not-for-profit organisation. A difference in role expectations and actual experience can lead to role conflict (Fondas and Stewart, 1994). As one Chair commented, NEDs either learnt to work within the limitations of the role or got frustrated and left. The experience of a NED role outside of the NHS meant many NEDs brought with them a particular understanding of the NED role from the private sector, with an emphasis on the compliance role. This might also reflect the requirements of the NHS at the time, when a dominant aspect was controlling expenditure.

Other influences

This study had initially sought to explore how factors, such as induction and training, might influence how the NED role was understood. However, few respondents could recall much about their induction to the role. The focus of ongoing training and development varied across PCTs, and a theme in analysis was that it was the PCT Chairs who played a major role in shaping these activities and the external events they allowed or encouraged their NEDs to attend. Some emphasised the development of business skills, others prioritised the development of local contacts and networks. This is discussed further in Chapter Seven, which examines the role of the Chair.

Section summary

This section has begun to examine some of the factors identified in analysis as influencing the NED role. These factors included the professional background of the NED as well as experience of other NED roles. Many of the NEDs in this study were from a business background, which led to an emphasis on those functions of governance related to finance, audit and risk. A different emphasis was seen in those from health or local authority backgrounds who saw their roles more closely aligned to the purpose of the organisation, such as in commissioning high-quality patient care, responsive to local need.

For the three NEDs with an NHS executive background this appeared to have particularly shaped their role. Their relationship with the executives was different, including greater access to the CEO, but they were more negative in their accounts with regards to the influence the NED could have on the board.

It was difficult to draw any conclusions about the influence of induction programmes or training but the influence of the Chair in how NEDs saw their role was an important one. The allocation of NEDs to different committees also influenced the role, such as concentrating on the audit function or a broader quality remit.

The next section considers how the salience of different identities may influence the governance role.

4.3 Influencing the role: Directors' multiple identities

Social identity approaches consider how social identification – the categorising of oneself and others as members of groups with distinct characteristics – influences behaviour. An important factor is the salience, or strength, of the identification which influences how individuals bring their behaviour into line with the group prototype (Augoustinos *et al*., 2006). People engage in strategies to protect the interests of their in-groups (Lucas and Baxter, 2012) and it has been

proposed that the salience of different identities can influence the governance role of the NED (Hillman *et al*., 2008). The approach of this study was to use insights from social identity theory to consider how the salience of different identities might have influenced the NED role.

Analysis of the accounts found evidence of four salient identities – an organisational one, a NED one, an identification with stakeholders and a broader public service identity – with NEDs having varying degrees of salience with each group. Social identity approaches see identity as' 'fluid and contextualised' (Augoustinos *et al*., 2006, p. 207), so what may be a difference in one context is not in another. For example, when considering the accounts of respondents, sometimes they identify with the organisation but a much greater strength of identification was with the NEDs as a distinct social group.

An organisational identity

In this study those who exhibited a more salient organisational identification were the six NEDs who were also chairs of audit. This post entailed a greater degree of organisational responsibility and time commitment (five rather than 2.5 days each month), so the stronger degree of identification was unsurprising. The audit chairs were more likely than other NEDs to talk about their role in terms of the organisation, not just their NED role on the board, as in this example from an audit chair in a PCT in the North of England, when describing his role:

> *I think my role primarily has been around governance and holding to account around governance and to some extent changing the culture of governance within the organisation so… the tone of the organisation I feel has been stiffened within a governance context as part of my role. I am chair of the audit committee so that helps.* NED 22, PCT Z.

The audit chair role was more likely than other NED roles to be seen as one of partnership with executive directors, with the NED able to bring his or her experience to support the executive team as well as a compliance-oriented role.

This would give some support to Hillman *et al.'s* (2008) suggestion that a stronger organisational commitment leads to the provision of additional resources as well as a monitoring role, though this study did not seek to test this proposition.

Exhibiting a low strength of identification with an organisational identity were seven local authority councillors who were also NEDs. From their accounts, they showed a weak identity with the PCT or board but more strongly identified themselves as councillors, serving the broader public interest through their role on the PCT board.

One other respondent who had a weak organisational identification worked in a social services department of a local authority and had joined the PCT board as part of his professional development. He also did not demonstrate any strong stakeholder identification, with the more salient identity arising from his professional background.

So the accounts showed a range of organisational identification, from a stronger identification by audit chairs to a very weak one by councillors, with the majority of NEDs showing a weaker identification with the PCT as a whole, rather than with the NED role. The part-time nature of the role is an obvious factor but it appears that some NEDs put different boundaries around this, with many narrowly defining this as their board role but others having broader boundaries that saw them more involved in the organisation, not only in terms of time but also the range of activities, which might include a blurring of roles between NED and management. This included the role of the audit committee chair but also NEDs who became more involved in the organisation, such as by choosing to contribute particular commercial skills and aligning themselves more with the success of the organisation.

The impact of timing and context may have influenced the degree of organisational commitment shown in the interviews, with the impact of the clustering of PCTs a relevant factor. For the few NEDs who had been appointed in 2010, the impact of their PCTs clustering with other PCTs a year later resulted in a low expressed commitment to either their single PCT or to the

clustered organisation. At this time of change, to be explored further, the NED role became more salient, with a particular emphasis on protecting the public interest, rather than organisational commitment.

The NEDs as a social group within the board

Whether the board – and particularly the NEDs – might be described as a particular social group could be questioned. The structure of the board was set down in legislation and all NEDs were part of the NED group by virtue of their appointment. However, while definitions of a social group vary, a basic principle is that members recognise themselves as belonging to a group and also identify the group by particular characteristics. Social identity approaches are not concerned merely with membership of a group but the salience of that identification (Augoustinos *et al*., 2006).

The PCT board was a unitary one, with both NEDs and executive directors serving on the board with a NED Chair. The guidance to boards made clear that all directors were collectively and corporately accountable for organisational performance (National Leadership Council, 2010). However, the most salient identity arising from NEDs' accounts was to identify themselves as part of a NED subgroup of the board, rather than with the board as a whole.

Only one NED identified himself as a member of the board, as opposed to a group of NEDs. This stronger board identification appears to be a result of particular board development the board underwent, which the respondent attributed to helping them to focus on how they worked together a team. While board development activities occurred in other PCTs and are reported approvingly by NEDs as increasing board effectiveness, all bar this one NED identified themselves as a distinct group within the board.

A Chair in the North-west of England, reflecting on the difference between the PCT board and other boards in the private sector where he had served as an executive, noted, '*I don't get a strong collegiate sense in terms of the wider board, the non-execs and execs together'* (Chair 12, PCT R). This was supported by other accounts.

For NEDs in this study, identification with the group of NEDs had a much greater salience than with the wider board or organisation. The following excerpts from an interview with a London NED, with a local authority background, illustrate this:

> *I suggested to the chair that we as a group of NEDs should meet before the board meetings, or should meet separately, because I felt that we needed to develop ourselves as a team.*
>
> *I think we were… as a group of NEDs, I mean we weren't all the same, but we were all of a similar… a similar approach I think. We were quite robust…*
>
> *And I think because the execs saw that although we were different, we respected one another as NEDs.* NED 3, PCT L5.

Here the NED used the third person (we and us) to describe her membership of the group of NEDs and made clear who were the out-group members (the executive directors). The unitary model of the board with executive and NEDs was generally considered by NEDs to be a model that worked well, but from the interviews it emerged in analysis that this was seen as a board with two groups, where successful working depended on the relationships between the two, rather than a unitary board where all directors had a corporate role and were unified in their board roles. This study would support the findings from the private sector of Stiles and Taylor (2001) that NEDs did not consider themselves a team with the executives but rather as separate teams.

Social identification with a group typically means that the attributes of that group are seen more favourably than other 'out-groups' (Hogg *et al.,* 1995). In these accounts of the NED role, the NEDs are generally portrayed in a favourable light, where failings of the board are more likely to be attributed to the SHA or to executive directors within the PCT. One NED from the North-west of England made clear that the executive directors must take responsibility for the financial

deficit of the PCT, rather than seeing herself as a corporate member of the board that was charged with overall responsibility:

> *The directors are the ones that are being paid to do the job, as non-execs we purely come in to... hold them to account to make sure that they deliver what they said they were going to deliver.* NED 43, PCT U.

Other accounts demonstrated similar feelings, though were less explicit in their attribution of blame.

This distinction made between the two groups, NEDs and executives, may reflect the particular context at the time of the interviews. PCTs were to be abolished and the negative reflections on their achievements by the new Coalition Government may have caused NEDs to distance themselves from the executives. Knapp *et al.* (2011) suggest that the strength of the distinction made by directors and managers as two distinct social groups can be influenced by the organisational context, and the greater the distinction the greater likelihood of viewing the other group more negatively. This would receive some support from this study, where the greater distancing between NEDs and executives arose from the accounts of NEDs where the PCTs had experienced financial pressures. This finding of the PCT NEDs as a distinct social group, rather than identification with the wider board, is important when it comes to considering board dynamics.

Stakeholder identification

A further possible identification for PCT NEDs was with stakeholders such as local people or patients. Among those respondents who had a strong stakeholder identification were four NEDs who were currently, or had previously, been employed by the local authority. Their understanding of the role was closely aligned with a sense of place and working for local citizens. Their accounts more frequently referred to the name of the local area than other respondents did.

As a person can, and often has, multiple identities, it is possible to have both a strong organisational identification as well as with stakeholders, as was the

case for two NEDs with local authority backgrounds. While they demonstrated a salient identity with the local community, they also identified strongly with the board and organisation. Both these NEDs had previously been NEDs on an SHA board prior to their appointment with the PCT and what appeared in their accounts is a more salient organisational identity, more corporate in nature than the particular interests other NEDs with a strong stakeholder identification expressed. Their experience on the board of the SHA appeared to have influenced their PCT role, with the needs of local stakeholders balanced with meeting central requirements.

As discussed earlier when examining organisational identification, those NEDs who were also councillors had a weaker identification with the organisation and board but a greater identification with local interests. This London NED, who was also a councillor, saw the NED role as a representative one:

> *every resident in x… has been a patient or is a potential patient, or is currently a patient, so it's our job to represent them and make sure that they are properly represented in terms of, that their money is spent properly and services are suitable for them and work effectively, safely, that's really the role.* NED 9, PCT L8.

The need to ensure prudent use of public funds was expressed by other NEDs, but for those who had worked in a local authority or were councillors the focus was more specifically local rather than public accountability for ensuring good use of resources.

So far, insights drawn from a social identity approach have shown three possible social identities as influencing the role – an organisational identity, a PCT NED identity and a stakeholder identity with the local community or patients – acknowledging that a person may have multiple identities and their salience dependent on context.

Analysis of the data showed a broader social group many NEDs identified with, namely a group of people serving the public good in a non-executive role in a

public sector organisation. This group encompassed those who had a strong identification with the NED group and also those councillors who had a weaker identification with a NED identity compared to their councillor role.

A public service identity

There is a large body of research relating to public service motivation and while definitions vary, for the purposes of this study that by Andersen *et al*. (2013) is relevant: 'the orientation to do something good for others and society in the delivery of public services' (p. 295*).*

Much of the research on public service motivation is quantitative in nature and focuses on testing and developing theory on its different dimensions. It also concentrates on employees of public sector organisations, rather than part-time board members. The area of interest for this study is not public service motivation *per se* but rather how insights gained from identification with being a public servant, serving on the board of a public sector organisation, may influence understandings of the governance role.

Can 'public servants' be considered a social group? This broader identification by NEDs with a public service identity would fit with categorisations of a social group in that respondents self-categorised themselves as being a member of it and also associated it with certain values and prescribed behaviours (Augoustinos *et al*., 2006). This also proved to be the more salient identity than an organisational one, when there were tensions between PCT plans, informed by SHA priorities, and what NEDs saw as being for the public good.

In Chapter Two it was identified that while NHS boards might be modelled on the private sector model they had additional elements, which recent trends in governance often refer to as public governance (Osborne, 2006), including a greater consideration of public value. These values give direction to the behaviour of public servants and an example of their expression is what has become known as the Nolan principles (Committee on Standards in Public Life, 1995). Within society there will be people attracted to work for an organisation

that institutionalises certain public service values (Vandenabeele, 2007, p.551*)* and this was a motivating factor for many respondents in this study.

For many (92%) of those interviewed, an appeal of the NED role was that it was seen as enabling them to make a contribution to society. People spoke of wanting to '*make a difference'* or '*give something back'*. Some mentioned specifically that they wanted to contribute to the local community, when asked why they had applied for the PCT NED role, as in the following response from a retired accountant in a London PCT:

> *Firstly I think it was about wanting to use one's declining skills for some sort of public service capacity, that sounds slightly idealistic but you know, it was in that direction. I think secondly to make some kind of contribution to the borough in which I am living.* NED 8, PCT L11.

Other respondents also demonstrated a strong sense of place, naming their local area and the public benefit they hoped their involvement with the PCT could bring to this specific community. While this might seem similar to representing a specific stakeholder interest, these accounts showed a closer identification with public service and the role of the organisation in improving services to benefit the area rather than a narrower identification with particular local stakeholders.

People with high levels of public service motivation will be attracted to organisations compatible with these altruistic needs (Taylor, 2008). Many (67%) of those interviewed appeared to possess this public service ethos and had also served or were currently serving in other non-executive public or not-for-profit roles such as school governors or as charity trustees.

A theme from analysis was that there was an expectation of values and behaviours associated with the public sector board role. The Nolan principles (Committee on Standards in Public Life, 1995) were referred to directly by a few respondents with regard to their role, as in this response from a retired NHS

finance officer, now a NED, when asked about guidance for the role which had been particularly helpful:

> *I think the Nolan principles, I often think are, that, the sort of simplicity. A lot of it is about, I suppose, common sense, you could say. But the attempt at having the public-life thing set out in seven words if you like, is often quite useful and I often go back to refer to that.* NED 35, PCT F.

In their accounts NEDs also referred directly to specific Nolan principles such as accountability, openness and probity. While these principles are phrased with reference to personal behaviour, such as the need to be accountable to the public for decisions and actions, the holding to account of others responsible for the delivery of services was also seen as part of the NED role. This understanding of the role appeared aligned to the 'public voice' envisaged for PCT NEDs by Williams *et al.* (2007), where NEDs hold the executive to account on behalf of the public.

While the majority of respondents identified with a set of values associated with a public service identity, this did not mean they necessarily identified with the PCT as a public sector organisation; rather, the organisation in following central policies and demands was sometimes perceived as acting in a way that was in conflict with the public values individuals identified with. This came to the fore particularly with the transition of individual PCT management and governance functions to a cluster of PCTs prior to abolition.

This section has identified how many NEDs exhibited a salient social identification with a group of public servants, serving the public interest, whether broadly seen as the wider public or more specifically local stakeholders. There was a small group of three NEDs who saw the role more as a job to gain them specific experience or an income than as a form of public service.

Different types of NED serving different interests?

Within public sector governance studies an area of interest is the two-stage

relationship between the public to elected politicians and then from politicians to managers (Hinna *et al.,* 2010). Questions when considering agency theory in the public sector are, who might be identified as the principal? And whose interests need to be protected against possible managerial self-interest?

Analysis of the interviews and consideration of the influence of background and salient identities led to the identification of two groups of NEDs, serving different interests. The first group, as earlier identified, were 14 NEDs (45% of NED group) who saw the principal as local people or patients, and their role to promote and defend this interest to create a locally responsive organisation.

The interests of the second group were less clear-cut. For some Chairs being a public servant meant serving the elected government and they saw their direct accountability as to the Secretary of State for Health. For NEDs, rather than the Government's interests, it was the wider public interests they were there to protect by ensuring an effective and efficient public service, as in these examples from two London audit chairs:

> *I was very clear that there would therefore be a strong governance role to it in ensuring that you know, public money was spent… according to you know, the three e's, effectively, economically and efficiently.* NED 16, PCT L3.

> *But I think overall the governance is, is good because we need to, because we are accountable to the public for the funds.* NED 24, PCT L6.

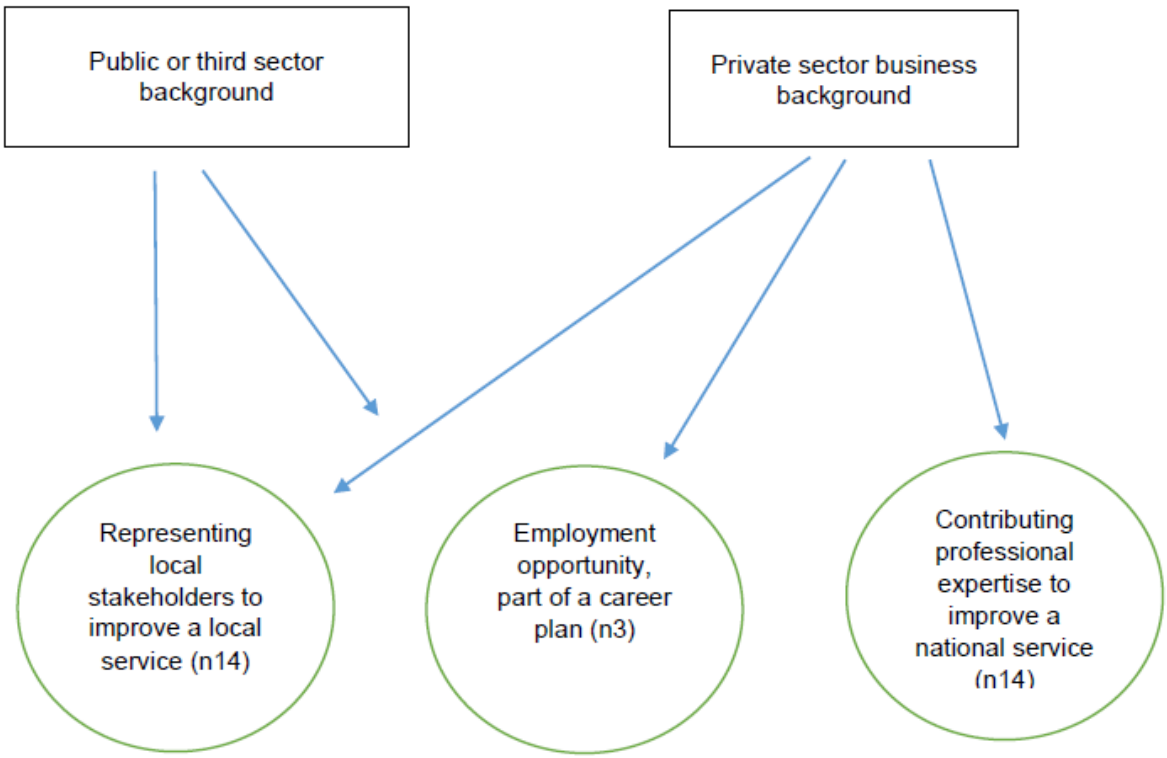
This general public accountability for public funds was dominant among audit committee chairs, for whom it was a key responsibility, but also for other NEDs with business backgrounds. While the provision of an efficient and effective service may be seen to be in the Government's interests as well as the general public's, as will be explored further these interests were not always perceived to be aligned and NEDs resisted Government policies felt not to be in the public interest.

There was then a third group of three NEDs whom, as already identified, did not appear to have a strong identification with any particular stakeholder group and the interests they saw their role as serving were difficult to ascertain.

The boundary between the groups is likely to be less distinct and relies on self-reports to a researcher who was also a NED, so there may have been a desire to emphasise the altruistic element of public service (and our common membership of this group).

These three different groups of NEDs identified from the analysis are shown in figure 4.1. Those from private sector business backgrounds are represented in all three groups. Those NEDs who had a public or third-sector background had a more salient local identity, with one exception for whom the role was seen as one to gain additional experience.

Figure 4.1: NEDs serving different interests



Included in the group of 14 NEDs, with a salient local stakeholder identity, were nine who clearly identified themselves as coming from a public service background and saw themselves as distinct from 'business-type' NEDs. One NED with a business background was also a councillor, and he positioned himself as coming from a public service background, rather than as a businessman. He gave an example where he and another NED with a local authority background made what he felt was a major contribution in improving GP services in their part of London, although this involved some conflict with GPs:

> *For all this guff about oh, we must have business people, actually in my experience, quite a lot of business people don't like that kind of stuff. And actually it was interesting, it was having a public service background that particularly made a difference there I think.* NED 2, PCT L2.

Chapter One described how the role specification for NEDs had changed in 2006, with a greater emphasis given to business skills. Those who saw themselves as 'community' or representing local interests resented this preference, with one North of England NED appointed in 2002 self-categorising herself as part of this group, which she characterised as having '*motivation, passion, time and public interest'* which she felt was lacking in '*high fliers'* NED 15, PCT W.

Section summary

There will be a range of identities and social identities which may influence the board role, and analysis of the accounts found four relevant social identities – an organisational one, a NED one, a public service identity and an identification with stakeholders, with some NEDs having a salient identity with more than one group. The organisational identity was generally weak for NEDs, though stronger for audit chairs. There was a greater identification with the PCT NED role, a local stakeholder identity and a broader public service identity.

The salience or strength of these different identities influenced the governance role, with those with a salient local stakeholder identity seeing part of their role as representing local stakeholders and protecting their interests. This group was more likely to be councillors or to have worked in the local authority or third sector, though some had private sector backgrounds. However, the majority of those with business backgrounds position themselves as experts bringing their professional expertise to improve a public service, responsible to the wider public for increasing the effectiveness and efficiency of a public sector organisation.

Chapter conclusions

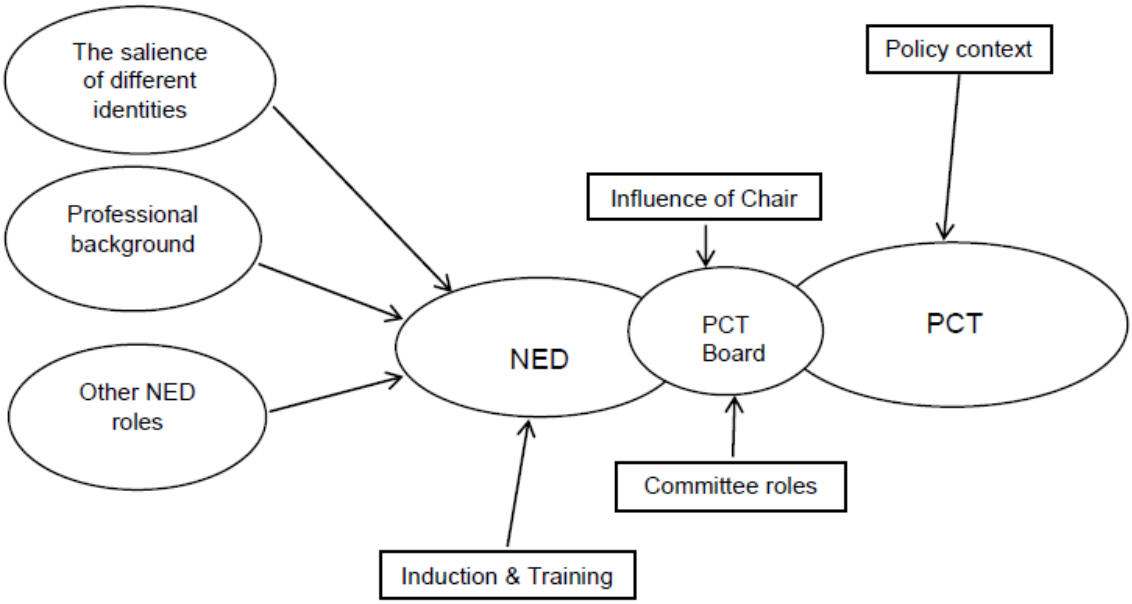
This chapter began by exploring NEDs' perceptions of their role. The dominant role that arose from their accounts is a conformance-oriented one (Tricker, 2015), similar to that found in the private sector, involving the monitoring of organisational performance and providing appropriate challenge to managers. While a strategic role is identified, this appeared to be located more within the control aspect of the role rather than in the development of strategy, unsurprising in a public sector context although future chapters will show ways NEDs were involved in shaping strategy. The presentation of the role reflects agency theory, which underpins roles envisaged for NEDs in monitoring management to ensure possible self-interest is kept in check (Daily *et al.,* 2003; Chambers *et al*., 2013).

The service role of PCT NEDs providing advice and resources is also similar to their private sector counterparts (Hillman *et al.,* 2009). Yet this chapter has begun to identify how the role in the two sectors might differ, themes that are to be further explored and developed.

Different factors identified in this chapter that may have influenced NEDs' understandings of their role are shown in figure 4.2. This chapter examined how factors such as the professional background of the NED led to different emphases within the role, such as on financial control or – for others – roles in ensuring high-quality responsive patient care. Other relevant personal factors

included experience of other NED roles and the salience of different social identities. The Chair was also influential in determining the type of role s/he wished the NED to have, the induction or training programmes provided for NEDs, and in allocating specific committee roles. The role of the Chair is examined in greater detail in Chapter Seven, along with the broader policy context that influenced the PCT board.

Figure 4.2: Different influences on the NED role



The influence of social identity on role was of interest in exploring how the NED role might be different in the public to the private sector, which may be related to the salience of different social identities (Hillman *et al*., 2008).

The influence of salient identities with either public service and/or local stakeholders, plus the influence of professional background, led to the identification of three different types of NEDs' role. Many of the NEDs in this study had a business background and for one group their role was contributing from their professional knowledge to improve a public service and promote the broader public interest. This meant increasing its efficiency and effectiveness through an emphasis on functions of finance, corporate governance and administration, functions Abbott *et al.* (2008) saw as the main tasks of the PCT boards they studied.

There were then a group of NEDs who had more salient identities with local stakeholders and saw their role as protecting these interests. A third group considered they had skills the PCT needed but saw the role more as a form of employment than of public service.

While the third group might be similar to the role in the private sector, for the other two groups a key difference is the influence of a public service identity and a view of the role as a defender of public interests, whether narrowly defined as local community and patients or more broadly defined as the wider public. These interests were to be protected and defended through a conformance-oriented role informed by expertise and experience from the private sector or a representative one, plus the contribution of skills and knowledge as necessary.

This finding of a role for the role of the NED as promoting and defending public interests is different to what may be found within the private sector. This provided a motivation to act and to adapt the role when it was required to protect patient or public interests, an aspect to be explored further.

The next chapter examines the process of governance and in particular the power NEDs were able to draw upon and utilise to make a contribution in the governance roles identified.

Chapter Five: The power and contribution of the NED within the PCT

This chapter examines the contribution NEDs considered they had made to the governance in the PCT. Implicit in the notion of contribution is that people, in this case NEDs, were able to bring about a result or alter a process that would not have occurred without their intervention. This draws attention to the process of governing, in particular the power NEDs were able to draw on to have influence in the governance of the organisation.

In addition to considering the different areas identified by NEDs and Chairs as areas of NED contribution, this chapter examines sources of power for NEDs and the conditions that influenced how that power could be utilised, using the tripartite analysis of power developed by Pettigrew and McNulty (1995). This chapter considers power, influence and contribution to governance by NEDs within the PCT. The following chapter examines the contribution of NEDs to the PCTs' roles and relationships with external stakeholders. The role and contribution of the Chair, as distinct to being part of the group of non-executives, is considered in Chapter Seven.

5.1 The power of the NED

The previous chapter saw that for many NEDs the role had a representative aspect, whether this was narrowly defined as local stakeholders or, more broadly, as the wider public. A simple definition of power is that it is the ability to affect the behaviour of someone else, and while such definitions are contested (Giddens, 1979) it is the relational aspect of power that is of interest and particularly, the 'ability to produce intended effects, in line with one's perceived interest' (Pettigrew and McNulty, 1995, p.851). The sources of power available to the NED and the ability of the NED to utilise these to produce results in line with their interests, such as identified in the previous chapter, is examined in this chapter.

While acknowledging these are self-reports, within the PCT NEDs' contribution included the monitoring of financial performance, the monitoring of the quality of patient care and the monitoring of executive performance, including the work of the audit committee and remuneration committee. These compliance-oriented roles were the dominant ones but were accompanied by contributions to strategy development and the provision of resources. These are discussed later after first examining the power NEDs were able to utilise to make a contribution and challenge the managerial hegemony identified in earlier NHS studies (Veronesi and Keasey, 2010, 2012).

The examples provided by NEDs of contribution were analysed using a tripartite analysis of power and influence (Pettigrew and McNulty, 1995). Power is conceptualised as a structural and relational phenomenon with a dynamic interplay of three elements, the power sources of part-time directors, their will and skill in utilising these, and the influence of context and structure.

Power sources for the PCT NED

From analysis, different sources of power for the PCT NED in their relationship with executive colleagues on the board were identified as professional knowledge, organisational knowledge that helped balance the information asymmetry between full-time executives and part-time NEDs, local knowledge and relationships, and the professional independence of the role. These are now examined in turn.

Professional knowledge

Expert power was identified by French and Raven (1959) as one of the five classic bases of power, and within this study it appeared a dominant one. From the examples given, knowledge gained from the commercial world, such as management and financial skills, would appear to be the most influential source of power. It was cited by 17 respondents as a particular contribution but also emerged as a dominant theme from the interviews when discussing the contribution of the NEDs, as for this auditor, now a London audit Chair:

> *I also brought to the picture good practice from my experience in the public sector having audited the health service and local government and all the rest over the years. So a lot of good practice I could bring in to the PCT. Some of it was applicable, some of it wasn't, but I think you get a chance to see how we measured up against others and to see where we could improve. So that's an area where I think I did contribute.* NED 11, PCT L9.

The greater recruitment of NEDs with business skills following the 2006 reorganisation of PCTs was seen by several NEDs and Chairs (all with private sector business backgrounds) as leading to a more rigorous level of challenge to executive performance. The level of expertise brought by NEDs meant a greater scrutiny of finance and performance but also that the challenge was more likely to be accepted by executives, who respected their professional credibility.

The influence of this particular group of NEDs may reflect the particular mandate given: the 2006 reorganisation emphasised that PCTs were to become more businesslike in operation, so NEDs with a private sector background were recruited with a particular expectation that they would help change the PCT into a more businesslike model. The internal context was important too, such as where the financial situation meant that NEDs with relevant experience felt given a mandate to assume greater power and authority in operational matters. Power derived from professional expertise could also be accompanied by greater personal authority, gained from the permission of the Chair of the PCT to act in a certain way, as in this account from a retired accountant, recruited to a PCT in the North of England in financial deficit in 2006:

> *And I said to the chair you know, what do you want from me, and he said above all else I want you to crawl all over the finances of this organisation.... So that's what I did… and at times I think my challenge was key to ensuring that because I've stopped one or two, what I would describe as flights of fancy being included in the financial plans of the organisation.* NED 20, PCT W.

The scarcity of commercial knowledge meant this commodity had particular value and power when the policy requirements required greater competition within the health services. Those who had commercial experience were able to strongly influence policy and process as well as become operationally involved where there was low executive experience, as for this London NED, later Chair, with a banking background, who referred to the lead he had taken on the procurement panel and also in recruiting to a commissioning support organisation:

> *And that wasn't just because we've gotta have a NED do it but in that case I think it was felt that having done things commercially that it would be very very helpful for me to be involved with it.* Chair 16, PCT L3.

The skills brought from business and also from other board roles, whether executive or non-executive, also appeared to critically influence another source of power – information – that is examined next.

Information

Information is a source of power (Raven, 1965, 2008) and some studies into boards in the private sector have considered the information asymmetry between full-time executives and part-time NEDs to lead to management hegemony, where the Chief Executive is able to control the board (Mace, 1971; Lorsch and MacIver, 1989). Within this study the amount of information received by NEDs was viewed as problematic by some, with NEDs sometimes struggling to identify the key points and decisions required. Those with knowledge of other boardroom practices were not only able to suggest improvements but were also assertive in seeing them implemented, as in this example from a retired director in the South-east, with other NED roles on FTSE 100 companies:

> *We've also managed to change their culture such that we don't get so many huge papers on things that go for information, that have been before, because we said look, just show us points that have changed… and saying what is it you really want of us and, remember, we're not as involved as you are on a day-to-day basis, you know we have to step back we've all got other things we're doing so you have to… you have to*

be really explicit and let us know what it is you're showing us and why. NED 25, PCT G.

Not that the board papers were the only source of information NEDs relied on. From all accounts, NEDs regularly sought additional information from executive officers, either by ringing to discuss forthcoming papers prior to a meeting or through informal meetings.

Of interest, the NEDs who had previously been NHS managers were the only ones to identify that executives may actively limit the information provided to NEDs, as demonstrated by this former NHS accountant reflecting on his role: '*you can only actually comment on what you know and what you know is what you are told'* (NED 22), and so the power of the NED was constrained by the actions of the executive in choosing which information to share. This NED saw the role as having only limited impact, perhaps influenced by his own first-hand experience of executive behaviour with regard to information provided to NEDs, giving support to managerial hegemony theory, which sees the full-time professional manager effectively controlling the board (Mace, 1971; Lorsch and MacIver, 1989).

However, if actions, structure and context are seen as part of a dynamic process (Giddens, 1979) where actions lead to the production and reproduction of structures, then this organisational context can be – and was – changed. As will be explored further, many NEDs actively sought out the information they needed and found it willingly given, thereby addressing this power asymmetry with management and changing the context for future actions.

While particular business knowledge appeared as a valued source of knowledge within the current context, so gaining its owners particular status and power within a low-experience environment, other sources of information such as local knowledge also gave NEDs a source of power within the boardroom.

Local knowledge

A clear theme from nearly all (96%) respondents was that knowledge of the local community served by the PCT was beneficial for the role in order to

understand its geographical and historical context, and the expectations and experiences of local people using health services. This was an important source of information that might support or challenge reports provided by executive directors who did not necessarily know the area well, as for this accountant in a PCT in the North-east of England:

> *One of the things you are doing is triangulating information that you hear from elsewhere and try to square that with what you're being told by the PCT and if you have a network outside the PCT, but one that is local, you can pick up a lot about patient views about the NHS for example*. NED 44, PCT Q.

As well as being able to utilise local knowledge to challenge executives' accounts of performance, those NEDs who identified a role in representing local interests used their knowledge to advise the PCT on how to successfully implement plans locally, including how to communicate board decisions to particular stakeholder groups. The resourcing role and the agency one are closely aligned (Hillman and Dalziel, 2003). Here, NEDs, able to contribute complementary local knowledge, were able to help the PCT fulfil its role as a local NHS organisation as well as use that information as a source of power in the monitoring of performance.

While those NEDs who considered themselves as having a more representative role saw their local knowledge as particularly important, for seven of the NEDs, from business or NHS backgrounds, this local knowledge was considered less important, or important only in gaining the PCT board local credibility. This London NED, with a previous managerial background in the NHS, voiced his concerns about people claiming to know the local area just because they live there:

> *So I have a healthy cynicism I think about this notion of the local connectedness and I want to always challenge what does that all add up to?*
>
> *I think that the single most useful report about what's going on in (x) is the public health report, annual report, which offers an amazingly*

detailed analysis of the variations in this, in my particular borough in (x). NED 18, PCT L1.

For other NEDs, ensuring appropriate involvement of patient groups and the voluntary sector were suggested as better ways of gaining community-specific knowledge, rather than relying on NEDs' local knowledge.

The findings of this study show that NEDs from different backgrounds drew on different sources of power. Those from business drew heavily on their expertise, which had a particular currency within the policy context and accompanying personal credibility. They may have also been able to contribute local knowledge but this had lesser currency. But for those who saw the role as having a representative element, then the power derived from knowledge of the local area and its populations was an important one.

Relationships and networking

NEDs who saw themselves as having a more representative role were able to not only draw on local knowledge but also had an additional source of power gained through relationships with key stakeholders. Councillors in particular drew upon their relationship with the council to resolve tensions between health and social care. They were also able to apply political pressure – a route not open to NEDs, as in this example from a councillor and NED in a London PCT, discussing his role in progressing a local hospital redesign:

> *As a councillor if you don't think things are moving we can speak to our local MPs or contact the ministers and kick start things into action which is quite a useful thing to have when you are trying to get big changes through where everyone technically agrees with them but you still can't get the thing moving with the natural inertia of the system.* NED 9, PCT L8.

Other NEDs proactively built up their influence through creating new alliances with others in the health economy, arranging meetings with key stakeholders such as GPs. This networking enabled them to bring into discussions views of

stakeholders, which could help influence decisions and gave them further credibility.

This proactive relationship building across the health economy appeared more developed and influential in some areas than others. The ability of some PCT NEDs to utilise their leverage in the wider health economy to bring about change was largely dependent on the actions and beliefs of the Chair who led on this and instigated the opportunities for influence. This is explored further when considering the role of the Chair.

Internal relationships were also important. The previous chapter considered how professional background might influence the role. NEDs who had previously had executive roles within the NHS appeared to have greater influence by being able to raise issues directly with the Chief Executive of the PCT, as did councillors, whereas those from other backgrounds, such as the voluntary sector, did not appear to have the same ease of access.

Other sources of power were those derived from formal positions within the PCT such as the Chair of the audit or quality committee. The legitimate power (French and Raven, 1959) bestowed by these positions enabled the NED to act in more assertive ways than in other settings and is to be considered further.

The sources of power so far identified are similar to those identified in the private sector: the possession of relevant knowledge and the ability to draw on personal networks both within and outside of the board (Pettigrew and McNulty, 1995). A further source of power identified here is one that arose from the structural power given to NEDs as independent board members.

Chapter Two discussed the greater monitoring role given to private sector NEDs to protect shareholder interests, arising from the Cadbury (Committee on the Financial Aspects of Corporate Governance, 1992) and subsequent reports. Within the private sector the independence of the NED is an area of interest, considering for example how this might be influenced by other executive positions. In the NHS, where NEDs are not allowed to have executive positions within the NHS or other NHS NED roles, these same issues do not arise but the independence of the role is challenged from a different perspective.

Independence of appointment

NEDs and Chairs were appointed by the Appointments Commission and were supposed to be independent of the PCT. This independence was to enable them to fulfil an independent role on the board, as set out in their roles and responsibilities (Appendix A, p.293).

Across the interviews, for some NEDs (21%) the independence of the position was seen as a significant source of power, as for this Chair of a South-east PCT, talking about both her power and also that of the NEDs:

> *I think the most important thing that you bring to the table is independence… So you come as your own person, as an independent scrutiny and an independent individual, with your own interests and your own slant on the issues that you're faced with. And I think that that independence on the board is very valuable. And the non-executives and the Chair are not accountable to the chief executive.* Chair 30, PCT F.

This Chair had been Chair of a PCT since its inception and Chair of another NHS Trust prior to that. Those Chairs who had been in post the longest gave greater emphasis to the independence of the role but also felt this had been increasingly challenged in recent years. As will be explored further when considering the role of the Chair, the exercise of power changed the rules of the game for further encounters: as these experienced Chairs exercised their power in relation to the SHA so they felt they had greater power in subsequent encounters. The exercise of power afforded by their independence led to NEDs, in the PCT referred to above, exercising their autonomy against the wishes of the SHA on a couple of occasions, examples which are explored further in the next chapter. This former NHS manager, a NED in the same PCT, explained what he had been able to contribute:

> *Bringing, and I guess, bringing a sort of independence that my livelihood didn't depend on decisions I'd make as a NED. Whereas I think often the, as an exec you, you've got your mortgage to pay next month.* NED 35, PCT F.

While NEDs' livelihood might not depend on the approval of the SHA, their appointment might. The SHA had a clear performance management role if a PCT was considered to be underperforming and failing to meet performance management indicators. It could initiate a review of the board and recommend personnel changes, with pressure being placed on the Chair or NEDs to resign (DH, 2011c). Where a board was considered to be failing, then the Appointments Commission took this into consideration when decisions were made to renew NEDs' terms of office. This led a couple of respondents in this study to question whether PCTs and NEDs were indeed independent as, if their board failed to meet the requirements of the SHA, they may lose their position. Once the abolition of PCTs and SHAs was announced this threat was weakened and there were examples, to be discussed later, where NEDs and PCT boards did take a more active stance against the wishes of the SHA.

Relationships within the PCT board could therefore be complex, with executives being influenced by what several respondents referred to as '*two masters'* – the board and the SHA. For NEDs to have influence, their independent status or possession of relevant knowledge alone was insufficient. The power of the NED was also dependent on their ability and skill in utilising these sources of power to influence executive directors.

Will and skill of the NED

Structural considerations of potential power sources cannot be separated from behavioural ones: structures arise from the actions of people (Giddens, 1979; Brass and Burkhardt, 1993). So, when considering the power of NEDs, the use of power is both constrained by structure and context but also contributes to them, which then in turn further constrains or enables action. The desire to act and the ability to use the power sources available forms the second part of Pettigrew and McNulty's (1995) analysis of power within boardrooms.

The previous chapter saw that many NEDs (90%) were motivated to serve on the PCT board as they identified with the values of public service, which saw them contributing to the good of society. This provided a motivation to act, to ensure that these interests – whether those of the broader public or more

specifically local residents or patients – were promoted and protected. However, while this might give PCT NEDs the impetus to join a board that did not mean they had any power to influence managers if decisions were felt not to be in the interest of these parties. Indeed, previous studies of NHS NEDs have shown them to have little power (Veronesi and Keasey, 2010, 2012). The ability of the NED to influence was therefore an important finding from this study. While different influencing tactics are to be discussed in greater detail, important prerequisites for effective influence were identified in analysis of respondents' descriptions of their relationship with executive directors.

The relationship between NED and executive

The previous chapter identified how for NEDs, in all bar-one of the PCTs included in this study, the NEDs and the executives were seen as two distinct groups on the board rather than as a unified board. NEDs saw their dominant role as conformance-oriented, including the holding of executives to account and providing challenge.

However, a clear theme that arose from analysis was that the NED needed to have the skills and ability to deliver this challenge in a way that did not result in an adversarial relationship with the executive. Rather, NEDs needed to help create the conditions where executives responded to the challenge set and a positive dynamic created. Two key characteristics identified as necessary for this relationship were trust and support.

Trust was required to work both ways: the NEDs had to be able to trust the managers and the managers had to be able to trust the NEDs. The word 'mutual' emerged several times from accounts with regard to relationships within the board, as in '*mutual respect', 'mutual trust and regard'* and *'mutual support'*. For executive directors, acting in a trustworthy manner meant being willing to give further explanation and information, not deliberately withholding it or misleading NEDs. For NEDs to act in a trustworthy manner, than this included abiding by certain norms of behaviours in public board meetings, such as ensuring managers were warned if a particular issue was to be raised that might otherwise leave the manager appearing unprepared.

Mentions of challenge by NEDs to executive directors in the interviews were nearly always qualified by the need for this to be within a supportive context, for it to be constructive without undermining or showing disrespect to the executives. However, the holding to account of the executive directors for their decisions or actions was seen as an integral part of the NED role, as in this example from a NED from a voluntary sector background in a PCT in the South-east of England:

> *I think the executives really listened to what NEDs were saying, took it on board and followed up with action. Occasionally there was a situation where a decision, a discussion and decision was made and it wasn't followed up in the first instance and needed to be repeated. But in the main there was a very constructive relationship between executives and non-executive directors and a very mature understanding of the importance of constructive challenge.* NED 34, PCT E.

While NEDs saw challenge as an important part of accountability within the board, there was a perception from just a couple of respondents that it was not always welcomed by some executives, which was attributed to a lack of awareness on their part that this was the NEDs' role.

These relationships between NEDs and executives were seen as something to be worked at and developed, particularly when there were changes in personnel or new policy challenges such as the World Class Commissioning assurance programme (DH, 2007). This was developed through board development workshops and also through the leadership given by the Chair.

Chairs played an important role in setting the tone for the board and creating a supportive environment, with one NED commenting that unless the Chair '*led from the front'* it was difficult for the NEDs to make an effective contribution in challenging executives or the policy requirements of the SHA.

The PCT board meeting: a public performance

One area identified from analysis as important for building constructive NED/Executive relationships was the approach to be taken at public board

meetings. From accounts, across all PCTs, this was a meeting guided by norms of behaviour, confirming studies in the private sector (Pettigrew and McNulty, 1995). There was also resonance with the concept of the board meeting as a performance ritual, identified within the public sector by Peck *at al.* (2004). The public board meeting was stage managed as a demonstration of public accountability, but to be performed in a way that did not undermine the executive directors. While challenging questions from NEDs were viewed as welcome, they were expected to prepare the appropriate executive director beforehand so that they had the relevant information to hand. Any contentious board items would be discussed in arenas external to the formal board meeting, such as in pre-board meetings, as in the excerpt below:

> *to a large extent the large board meetings were the kind of staged… and I think that's inevitable, I would hate to have, you know, I don't think it would have been right for us to be having formal board meetings where we were meeting… talking about stuff that we didn't, we hadn't met before.* NED 14, PCT Y.

This NED from a PCT in the North of England had also served as a NED on the SHA board. She referred particularly to the presence of the local press at the public board meetings, which restricted the range of views that NEDs felt appropriate to express in board discussions. The discouragement of any signs of overt conflict between board members meant that the NED role might be seen as a passive one, as a fellow NED from the same area commented:

> *What may appear to an external person or an observer that may have attended a meeting, is that things are being nodded through. NED 19, PCT W.*

He then went on to explain the range of discussions and debate that would occur outside of the boardroom prior to an item coming to the board for decision. Another NED, from a neighbouring PCT in North-east England, also stressed the importance of the board discussing agenda items prior to the public board meeting:

> *I think we do give ourselves some time to make sure that we're not getting to a board meeting or a situation where maybe one or two people are very het up about a particular issue and it's going to, if you like, burst out in the middle of a public board meeting.* NED 33, PCT P.

These three NEDs had all previously served as NEDs on an SHA board and they exhibited a strong identification with a public service NED identity and the expected behaviours of the group (Augoustinos *et al*., 2006). While the norms of behaviour at a public board meeting were agreed across all accounts, for these NEDs they had a greater prominence.

Those studies on NHS governance that claim to have found too much trust and insufficient challenge when observing NED behaviour at board meetings (ICSA, 2011; Abbott *et al.,* 2008) have failed to recognise the extent to which these are constructed events. From accounts of the NEDs in this study, the real challenge and interaction with executives occurred outside of the formal board meeting, either in committee meetings that enabled greater depth of discussion, or in informal arenas.

Outside of the boardroom: the informal role of the NED

From across all accounts, a range of interactions was identified between NEDs and managers outside of the boardroom. These included formal board seminars or workshops as well as informal meetings between individual NEDs and directors. From analysis, four different functions of these informal meetings were identified:

- To discuss in greater detail an item coming to a board meeting
- To prepare and discuss the agenda of a subcommittee a NED was chairing
- To share expertise with relevant directors
- To provide support for executive directors

The first two types of informal meetings, to discuss in greater detail an item coming to board meeting or to discuss the agenda of a meeting the NED was chairing, were aimed at increasing the NEDs' knowledge through seeking further information or a greater clarity of the issues through discussion with the relevant director. Information is a source of power (Raven, 1965) and NEDs in this study acted proactively to request further information prior to formal meetings, as in this excerpt from a NED with a community background in the North of England:

> *If there were difficult finance reports or something to get to grips with, the assistant director of finance knew that I'd be on the phone saying OK, just talk me through this paper, explain this because I don't see where this figure comes from and we'd spend half an hour to an hour on the phone.* NED 15, PCT W.

NEDs across all PCTs saw requests for further information as welcomed by executives. Chairs of board committees identified an important part of their role as meeting up with the relevant executive director prior to a meeting, ensuring they were fully briefed on agenda items, as with this NED in a PCT in South-east England who chaired a Quality Committee:

> *For the meetings I previously and currently chair, I would tend to meet before each meeting to, and speak over the phone, to agree agendas and check papers and also to seek any clarification so that I had a good understanding of the issues that were likely to come up and some of the things that perhaps weren't said in the paperwork but needed to be known.* NED 34, PCT E.

This study found that in addition to these meetings, related to board or committee papers, there were other informal meetings between NEDs and executives. These usually related to specific subject areas where a NED with relevant expertise would meet up with an executive director. This might be ad hoc or involve a more formal partnering between a NED and executive director, instigated by the Chair. These meetings gave the NED opportunities to contribute particular knowledge to help inform strategic proposals at an early stage as well as sometimes advising on operational details.

The extent of NED involvement outside of formal meetings could be seen as an overlap into management activity that might conflict with the conformance-oriented monitoring role. This did not appear to cause any conflict for NEDs and the issue of role boundaries will be returned to for greater discussion later in this chapter.

In addition to gaining further information or sharing relevant expertise with executive directors, these informal meetings could also be used to offer support, such as for this retired NED in a South-west England PCT:

> *So you know (I) sometimes wander into an executive and just make certain they are alright because… you can sit at the board meeting and think ah hah, bit of stress there.* NED 28, PCT B.

In an earlier study on PCT boards Abbott *et al.* (2008) suggest that NEDs were able to influence strategy outside of the formal board through their involvement in committees. This study supports this but also identifies the range and scope of NED involvement in the organisation, which went beyond committee involvement to include a range of informal and ad hoc meetings.

Acknowledging that these are self-reports, NED in this study appear to have exerted high effort norms in creating opportunities to gain further information to assist in the monitoring role and to share from experience with executive colleagues.

The influence of context

The ability of the NED to exercise power will be influenced by the context and structure of not only the organisation but also broader structures and expectations (Pettigrew and McNulty, 1995). As already identified, the interviews for this study took place at a time when the finances of NHS organisations were in the political and media spotlight, which meant those NEDs with financial skills and knowledge appear to have had greater power within the organisation then those who did not. It could be, though, that the context led to NEDs particularly emphasising these areas of contribution in their reports, rather than others.

Some of the contextual influences already identified include the board culture, expected behaviours of a public sector board and a respectful and non-adversarial relationship with executives. These might be seen as the 'rules of the game' NEDs are socialised into but also reproduce through their own actions. Following the approach of Giddens (1979) and Pettigrew and McNulty (1995), these structures and context do not merely constrain action but are reproduced by them. The actions of NEDs will influence the context for future board encounters. The next chapter explores how the changing external environment, once the abolition of PCTs was announced, led to different roles for NEDs and also influenced the power dynamics within relationships.

Section summary

Different sources of power for NEDs identified in this study include some of those identified by French and Raven (1959; Raven, 1965). These include expert power, such as business knowledge and local knowledge, information power about the organisation gained from executive colleagues, and legitimate power gained from their appointment, with additional authority gained from chairing key committees and the professional independence of the post.

Those from business backgrounds drew heavily on their professional expertise, which had a particular currency within the policy context and which gave them personal credibility. The possession of local knowledge may have given additional power and credibility but for these NEDs appeared to be less important.

However, for those NEDs who saw themselves as having a more representative role, and in particular those who were councillors, their local knowledge and ability to represent particular stakeholders was seen as a counter-power to the more dominant professional one. They also sought to increase power through external alliances with key stakeholders, particularly the local authority.

A strong theme from analysis were the norms of behaviour and the skill of the individual NED in being able to work within a constructive relationship that balanced both challenge with support.

This section has identified personal sources of power and opportunities for NED influence both within and outside of the formal board setting. The next section examines in greater depth the manner in which that influence may be exerted and the contribution made.

5.2 Exercise of power and influence

The contribution of NEDs to PCT governance was an area of particular interest for this study. In addition to exploring areas of personal contribution respondents were asked for specific examples where NEDs, by their actions, had made a difference to governance within the PCT. These included examples given by Chairs of NED contribution in their PCTs. A few respondents provided more than one example leading to a sample of 54 incidents of NED contribution that were analysed to identify *how* NEDs had been able to influence decisions and outcomes. These actions are examined first before returning to look more specifically at areas of contribution.

Different methods of influence identified by McNulty and Pettigrew (1996) include persuasion (both reactive and proactive), coalition formation, assertiveness, consultation, pressure and blocking.

These methods of influence were used initially to analyse and code the data. It proved difficult to differentiate between applying pressure on executives to make a decision and persuasion, as only the NEDs' construction of events was available. What may be considered pressure is a subjective view, so this category was dropped. An additional category, however, was identified from analysis, which was labelled 'influencing pre-decision'. While this might be seen as a form of consultation, where NEDs were able to participate in planning a strategy or change, the data revealed opportunities for influence at earlier stages of decision making through informal meetings outside of the boardroom, as already discussed.

The findings of this study differentiate between the use of power and that of influence, following the approach of Lucas and Baxter (2012). Influence is

identified as achieving results through convincing people it is the correct action, rather than through the more negative tactics associated with power, such as promise of reward or threat of sanction.

Across these examples of contribution the frequency of different uses of power, such as blocking and assertiveness, or influence such as persuasion, consultation, influence pre-decision and using internal or external support, are shown in table 5.3. The method used most frequently was reactive persuasion, where NEDs responded to information provided by others to persuade them as to a different course of action. Rather than the forming of coalitions, in this study NEDs drew on sources of internal and external support, and these are considered further in the next chapter.

Table 5.3: Methods of power and influence used by NEDs

Methods of power and influence	Number of times identified in examples
Methods of power	
Blocking	3 (5%)
Assertiveness	10 (18%)
Methods of influence	
Persuasion: reactive	14 (26%)
Persuasion: proactive	7 (13%)
Consultation	7 (13%)
Influence pre-decision	5 (9%)
Using external support to have influence	4 (7%)
Using internal support to have influence	4 (7%)

Using power: blocking and assertiveness

From the examples given in interviews, NEDs appear to have utilised power less then they utilised influence to get results, where power is seen as a more negative tactic. There were only three examples in this study where NEDs reported blocking a decision. Two of these related to proposals for expenditure on information technology, rejected by NEDs as not considered good value for

money. The third was a public health recommendation for which NEDs considered they had had inadequate information and opportunity to consider. A possible reason for this low number of instances where NEDs blocked a proposal is that there would have been opportunity for influence beforehand to avoid this public loss of face, as already identified when considering the public board meetings. This Chair, in North-west England, explained the approach in his PCT:

> *But usually if there was something controversial coming up, I would know of the concerns of the non-exec directors, and I would feed that into the chief executive at an earlier stage, so that when it arises as a strategy or a proposal it's already been influenced, by the input from the non-exec directors.* Chair 40, PCT T.

While the blocking of a decision may be the most obvious manifestation of power, the power of the NEDs to influence may not always be visible through an examination of board behaviours and minutes. As this study shows, it can be exercised subtly outside of the formal arena and pass unrecorded.

Assertiveness, where NEDs were able to insist upon compliance, arose from a position of authority, and NEDs drew on either their majority on the board or, more frequently, their chairmanship of committees to insist that the executives carry out a course of action. This Chair in a Central England PCT gave an example of the role one of her NEDs had played in ensuring that the PCT met national targets around treatment times:

> *An example of that is a quality and performance committee where the (NED) is very clear about, we want to move this to an outcome-based agenda and so because we want to make sure we have very timely information so you know, in terms of laying down the expectations and the principles and then working with the director to make sure those are delivered and having to have some hard conversations about you know we don't appear to have moved on, we are not hitting this performance target on cancer… Why is it, we need to do something differently we are not just going to… we are not sitting here to receive the same information*

meeting after meeting we need to see movement. So it's actually that sort of discussion. Chair 38, PCT M.

Other examples of assertive behaviour related to the work of the audit committee and remuneration committee, where NEDs insisted on certain course of action.

However, NEDs' preferred mode of influence was to draw on their expertise to persuade executives of the rightness of the course of action suggested, with the exception of examples of assertive behaviour within committees. This could be because committee meetings were not public meetings, so there were not the same norms of behaviour. It might also be that these committees were more organisationally focused and chaired by NEDs, which gave them legitimate power to act in assertive ways, rather than seeking to influence. This is explored further in the next section.

Methods of Influence

Persuasion

The most common (39%) form of influence identified from examples of NED contribution was persuasion. Yukl and Tracey (1992) describe this as the use of logical arguments and factual evidence to persuade others that the course of action proposed is viable and likely to achieve task objectives. McNulty and Pettigrew (1996, p.172) differentiate between reactive or proactive persuasion, with reactive persuasion a response by NEDs to information provided by others and the latter where the NEDs are the influence agent and the executive directors the target.

Within this study, examples of proactive persuasion were where NEDs initiated actions leading to outcomes that might not otherwise have happened but for their intervention. This included championing the interests of particular groups of patients whose needs were seen to be given a low priority by executives, with examples given around wheelchair provision or services for people with learning disabilities, as in this example from a NED in South-east England:

> *We, the NEDs, me and one other particularly, but the NEDs collectively, felt that the exec, well, GPs were not pursuing the target of, generally were not pursuing the target of providing health checks for people with learning disabilities. And the execs, although it was a target, a national target, the execs were paying, we thought, pretty much lip service to it.*
>
> *And we forced the execs to pursue it much more vigorously and the performances improved, markedly really.* NED 35, PCT F.

Reports of contribution show that proactive persuasion was less common (13%) than reactive persuasion (26%). The latter seemed particularly focused on commercial decisions, where NEDs were able to draw on their business knowledge to highlight risks and persuade executives to modify proposals. An example given by an accountant serving as a NED within a PCT in the North of England was the governance of primary care contract management when this service was centralised across four PCTs to save costs. Whereas the other PCTs raised little objections, the NEDs within this PCT raised concerns about governance and accountability:

> *We as non-execs were quite concerned about that because it's a big chunk of our spend and we felt if it's moved to a separate organisation, where our only link will be through the chief executive… and the fact that they'll produce minutes back to our board, that's, that's not enough, you know we can't see how they're getting on really, we can't get involved in strategy etcetera. So we had quite a long and lengthy debate about that.* NED 44, PCT Q.

In this instance the NEDs were able to persuade the chief executive to strengthen governance arrangements, such as the creation of standing orders for delegated responsibility and the provision of more frequent reports. When considering why this one PCT board was concerned and the others were not, then the organisational history is relevant. Within this PCT a previous area of delegated responsibility around specialised commissioning had been found to lack sufficient accountability to the board, providing motivation for the NEDs in this PCT to not just rubber stamp the proposal but also to ensure it was modified in light of the risks to the organisation.

Consultation

Consultation occurs when someone's participation is sought within a planning process, with the person willing to modify the proposal in light of concerns and suggestions (Yukl and Tracey, 1992). Within PCTs, private board seminars were used to present proposals to NEDs and give them chance to influence these before any final proposals were made. As the Chair of a South-east England PCT explained:

> *Public board meetings are the formal public board meetings in public, with the public witnessing and every one does an executive or non-executive role and discuss the issues, but when it comes to workshops you want the best pooling of the expertise on particular issues. So the non-execs and execs team come together as people that have their own specialisation and therefore contribute to the, the solution, as it were, of whatever project we are talking about.* Chair 13, PCT G.

This example highlights the two aspects of the role already identified. There was the conformance-oriented one where the NED role was seen as challenging and monitoring executive performance and also a performance-oriented one. Within all PCTs included in this study, greater discussion of issues at board seminars were the norm and this switching between a collaborative mode helping to shape strategy and decisions in consultation with executives and then a non-executive mode scrutinising proposals did not appear to present NEDs with any difficulty. This supports the findings on the NED role in the private sector (Stiles, 2001; Roberts *et al.,* 2005) rather than the conflict suggested by Ashburner (2003) in early studies on NHS boards.

Influence pre-decision

The extent of involvement in strategy and policy also included the informal meetings with individual directors, previously discussed. Power may be exercised to influence and shape opinions before an issue is raised for decision, so no conflicting interests are observable. As seen, overt conflict was considered inappropriate for a public board meeting; instead NEDs utilised a range of informal meetings with executives to influence policy and strategy

before it became formalised and brought for consultation. This excerpt from a retired businessman in a South-east England PCT gives an example of this approach:

> *I go in and discuss any major issues particularly if I don't understand them and sometimes I find that the people I'm talking to haven't got a full understanding either, so we talk through it. I think there's a sort of quasi-mentoring role as well that we have sometimes, we certainly don't impose it, but if we feel that someone, and sometimes we are asked for our advice, what would you do?* NED 31, PCT F.

These informal roles NEDs adopted show a more collaborative relationship with executive colleagues rather than the conformance-oriented role initially articulated when describing their role and presented in the previous chapter.

Drawing on internal support

Chapter Four discussed the categorisation of NEDs as a distinct social group. From all accounts they appeared as a cohesive group on the board who, despite different backgrounds and interests, supported each other and acted corporately as a group. There was no indication that circumstances arose that meant NEDs had to form coalitions within the board to have influence on a particular issue, as found by McNulty and Pettigrew (1996) in the private sector.

This may arise from the difference in the two sectors, which led to different uses of power and influence. Examining the contribution of NEDs and Chairs in the study by McNulty and Pettigrew (1996), a major area of influence for NEDs was around personnel matters, including appointment and dismissal of the Chair. Within the PCT, NEDs had little influence on this, which would be within the remit of the Appointments Commission and the SHA.

However, there were a few examples where NEDs garnered extra support to support their position, such as lobbying an interim Chief Executive to persuade her to keep a community hospital open. The next chapter will explore further the action of NEDs in collaborating with external actors to have wider influence in the health economy.

Personal power and influence in board decision making

For some NEDs, their personal contribution to governance was in the conformance and performance-oriented roles, already identified. For others though, their contribution was identified as their personal skills and ability such as being able to maintain a clear focus and to think strategically. While challenge to executive proposals has already been highlighted as a key role for NEDs, a related skill identified was in being able to formulate the right questions to test proposals. Interpersonal skills were highlighted as a particular contribution for some, such as the ability to form positive relationships or to act in a mediating role, as for this NED with a social services background in a Central England PCT:

> *I sort of bring skills of mediation, I have to say, across the board where there are differences of view, and a level of moderation as well.* NED 27, PCT N.

As discussed earlier, the possession of sources of power, such as expert or legitimate power, needed to be accompanied by the skill to use these effectively in a board setting. Boards have been described as strategic decision-making groups (Forbes and Milliken, 1999) where process is important to ensure collective skills and knowledge are not lost but used to improve board performance. Some NEDs appear to have taken on a greater role in helping to create and maintain a cohesive board. Although acknowledging these are self-reports, for more than a third of NEDs (38%) in this study these personal skills were identified as an important contribution to board dynamics, in contrast to the NHS boards studied by Veronesi and Keasey (2011) where NEDs played only a marginal role, allowing managerial or professional expertise to dominate.

Section summary

This section has examined different uses of power and influence by NEDs. The main influence method utilised by NEDs was to persuade executives to either follow a course of action or to modify a proposed one. This was similar to the finding of McNulty and Pettigrew (1996) in the private sector. While there were a

few examples of the blocking of proposals and the use of assertiveness, methods of influence were used more commonly by NEDs in this study than the exercise of power. Having considered the sources of power NEDs were able to draw upon and the skills required to utilise these, the next section considers the contribution NEDs made to different board roles.

5.3 Contribution to board roles

The personal and collective contribution of NEDs is examined with reference to Tricker's (1994, 2015) categorisation of conformance-oriented and performance-oriented roles.

Conformance-oriented roles have a present or past focus. This study found NEDs contributed to the monitoring of financial performance and of the quality of patient care. Other areas of contribution by NEDs were performance-oriented, with a forward focus. These included involvement in strategy development and the provision of resources, acting as a source of external information and connecting the board to useful networks. These areas of contribution are now considered in more detail.

Contributions to conformance-oriented roles

As discussed previously, the majority (81%) of NEDs saw a dominant aspect of the role as monitoring executive performance. This section explores further the contributions made in that role.

Monitoring financial performance

With many NEDs from business backgrounds and the policy context one where the financial performance of PCTs was under scrutiny, it was unsurprising that one of the major areas NEDs felt they contributed to governance is in monitoring the PCTs' financial performance. It may also be the easiest area within which to identify an influence that can be quantified, particularly when the PCT was returned to financial balance after being in deficit. NEDs felt they had helped improve the financial standing of the PCT by providing scrutiny,

identifying weakness in financial management and challenging executive performance. This NED with a consultancy background in local government, described the situation at his PCT in Central England:

> *It was very clear that the executive team did not have a grip on it (the financial situation) and it was the non-execs ramping up their activities both at the full board, the finance and performance committee and at the audit committee that forced the executive team that we had at that stage to start getting a grip of basic financial management.* NED 42, PCT J.

While a key area of contribution of NEDs was in what Abbott *et al.* (2008) describe as second-order functions of finance, governance and administration, NEDs were also involved in the first-order functions of providing or commissioning healthcare. An aspect of this was in their monitoring of the quality of care and challenge to the PCT to improve performance.

Monitoring the quality of patient care

Part of the compliance role involved ensuing the organisation met performance targets as set out nationally in the annual Operating Framework or decided more locally by the PCT, which included targets related to patient care. Some targets were felt inappropriate by NEDs, such as around access to NHS dentistry. Other targets, however, such as referral to treatment time limits, were defended and actively championed by a few NEDs, notably those who saw themselves as representing stakeholders, such as this retired London social worker:

> *I suppose, I suppose I saw myself very much as a, having a patient perspective and because I understood about some of the targets and what they meant to the patients, it meant they weren't just targets, they were actually important in terms of ensuring that people received timely and appropriate treatment. I think that was, that was quite helpful.* NED 4, L5.

Other NEDs identified specific contributions to improving the quality of services through their membership of quality committees and raising issues for action. This role in quality had increased in emphasis in recent years, which is considered further in the next chapter along with the extended role of some NEDs in addressing quality issues across the health economy.

The contribution of the audit committee

Those NEDS who sat on audit committees had a remit that was clearly defined within that committee and saw a significant contribution to governance through their membership or chairing of that committee. The audit function included liaising with internal and external auditors and was generally considered to have worked well, with audit chairs feeling they had made a significant contribution to the organisation, as in the following from an accountant within a London PCT:

> *I think my contribution has probably been around the audit committee where I've focused upon it working in terms of getting it running, getting it working, making sure that the NEDs are contributing, making sure that we have the right papers and the right people for the meetings and that the agenda is robust and not overfilled.* NED 24, PCT L6.

There appeared a greater confidence around the audit chair role than other NED roles, and this was more comparable to similar roles in other organisations experienced by the NED.

The contribution of the remuneration committee

The remuneration committee of a PCT consisted entirely of NEDs. While the area of remuneration might be a major area of contribution within the private sector, within PCTs NEDs had limited powers in relation to executive pay. The majority of staff would be on national agreed paid bands. Salaries for Chief Executives and senior directors within PCTs had to follow national guidelines, related to the size of the population the PCT served, though there was a small amount of flexibility such as the awarding of performance-related pay. While they had limited powers, for NEDs who served on the remuneration committee,

it was seen as an important contribution with an awareness of the need for prudence in the use of public funds, highlighting an area of crucial difference in a public sector board to a private one, where accountability is to shareholders.

Performance-oriented roles

The performance role of the board involves a longer-term focus on goals and developing strategic direction and the necessary policies, systems and resources needed to meet those longer-term objectives (Tricker, 2015).

Contribution to strategy

Strategy for a public organisation is largely dictated by national policy, so is different to that developed within a private company with its greater freedoms to choose between different strategies such as to improve its market share. In the previous chapter when considering the NED role, the strategic element was presented by respondents as one where the board provided challenge and oversight of strategic decisions. However, analysis of accounts showed NEDs had a broader role in strategic decision making than this and included their engagement with directors in informal settings outside of the board in helping shape emerging strategy. There were also opportunities for NEDs to be involved in board seminars, particularly in developing the annual strategic plan. While national priorities may have dominated, there was still some scope for NEDs to influence strategic plans and ensure they reflected the needs of local patients. A London NED, also a councillor, cited examples in

> *Strategies around you know, dementia or end of life, they came to the board quite early so there was actually quite a lot of time to, you know, put stuff in or change it.* NED 21, PCT L11.

Another London NED, from a local authority background, identified a specific area of contribution she had made:

> *So I contributed to strategy, I particularly raised issues of equal opportunities and equalities because that's an area that I've got an expertise and a commitment to.* NED 3, PCT L5.

NEDs also provided challenge when strategic proposals came to the board, where they played a gatekeeper role similar to that described by Stiles (2001) in the private sector in setting the values and parameters within which strategic decisions were made. These values in the public sector related to the purpose of the organisation, such as ensuring quality of services for the patient.

There was also another aspect to the strategic role for PCT NEDs, shaped by the particular public context and quite different to the private sector role.

Any proposed major changes to services provided or commissioned by PCTs were required by law to go to public consultation and to involve a wide number of stakeholders (Health and Social Care Act, 2001; NHS Act, 2006). This legal obligation on the PCTs to consult with stakeholders on any proposed significant development meant that strategy development was not only different to the private sector because of the policy constraints but also that the process required wider stakeholder engagement if it was to result in a substantial variation to how services were provided.

While a legal requirement, for those NEDs who saw themselves as having a particular local or patient representative role, this active encouragement of greater citizen engagement and responsiveness was seen as a particular contribution made. This went beyond the boardroom, with these PCT NEDs personally attending meetings to listen to people's views on the proposed changes to services. NEDs took action to ensure that not only did stakeholder engagement take place but also that the consultation responses were taken into account when agreeing a proposed course of action. This influencing role may be one step removed from the direct contribution to strategy development, such as through the contribution of sector-specific knowledge, but demonstrates a stakeholder role of ensuring local interests are promoted.

Provision of resources

The provision of resources has already been identified as a key part of the NED role. The contribution of financial knowledge and business skills has been discussed but NEDs brought a range of experience to the PCT, such as for this London NED with a background in public health:

> *I have been working for some time in the areas of public health and sustainability, very much with and for local authorities and regional governments. So understanding policy and local authorities and that bigger health economy picture rather than being a sort of… someone with NHS through me like a stick of rock.* NED 6, PCT L4.

This contribution to the board of human and relational capital supports resource dependency theory (Pfeffer and Salancik, 1978) and, as already identified, the expertise brought by the NED also enabled more effective monitoring of executive performance.

Handling the tension of different roles

From the examples given by NEDs a range of roles is revealed, including those that appeared to overlap into a more operational role such as direct involvement in financial management. There was an awareness of the boundary between operational and governance roles, but operational involvement was justified as warranted by the context, as from the NED in the financially-troubled PCT in Central England referred to earlier:

> *So as non-execs we got a bit closer to the business than perhaps we should have. I think it was appropriate at the time.* NED 42, PCT J.

Other NEDs who contributed particular commercial skills, such as in procurement, also justified it as being necessary. This arose from a perception that the public sector lacked the expertise needed and, to help the PCT meet the challenges of a rapidly changing policy context, NEDs had to step in where there was a lack of skills within the management team.

From the reports of NEDs, their greater operational involvement in the PCT did not personally cause them any difficulty with their governance role; rather, there was satisfaction that they were able to contribute their skills for the benefit of the organisation. They could identify other NEDs as becoming too '*operational*' but, apart from specific circumstances that they felt justified their greater involvement, they felt they maintained appropriate boundaries between an operational and a NED role.

NEDs also did not identify any tensions between different aspects of their role, such as supporting executives and contributing to strategy and then stepping into a compliance-oriented role and holding the executives to account. They appear to have been able to have held in tension the dynamic identified by Roberts *et al*. (2005, p. S21) of being engaged but non-executive. However, some Chairs were more hesitant in allowing their NEDs to have greater involvement in the PCT for fear that this would reduce their ability to bring external scrutiny.

Section summary

When analysing the examples given of how NEDs felt they, personally and collectively, contributed towards governance in the PCT, the conformance-oriented roles dominated. This may reflect the business background of the NEDs, the particular policy context or just that these areas were the ones they felt more clearly able to identify their contribution. However, there were also examples where NEDs felt they had contributed to performance-oriented roles, such as providing scarce resources and strategy development, although this might be centrally determined with only limited ability to influence. From their accounts, NEDs appeared able to play a range of roles within the PCT, some which might have appeared to stray into management, without these coming into conflict or causing any personal difficulty.

Chapter conclusions

This chapter examined the contribution of NEDs to governance and considered the power NEDs were able to exercise to achieve results in line with their interests. Studies within the private sector (Lorsch and MacIver, 1989) and more recently within the NHS (Abbott *et al.,* 2008; Veronesi and Keasey, 2011, 2012) have suggested that the board is dominated by managerial capture, with the NEDs marginalised. However, this chapter identified how NEDs were able to exercise power and influence to make a contribution to governance in a range of areas.

Behavioural approaches to governance consider the dynamics of board processes, and this chapter has examined the sources of power PCT NEDs drew upon to have influence within the board. These included expert knowledge and legitimate power (French and Raven, 1959) drawn from the possession of valued skills and expertise and the authority formally derived from chairing key committees.

Access to information was an important source of power, with NEDs actively engaging in behaviours to improve the information they possess, supporting findings in the private sector (Roberts *et al.,* 2005). In this study nearly all NEDs actively engaged not only in seeking out more information, but also testing it, probing it and exploring with executives their understanding of it. They also sought out corroborating or disconfirming information from other sources, gained from meetings with stakeholders such as GPs.

Within the PCT, compared to the private sector (McNulty and Pettigrew, 1996), NEDs appeared to use power less and influence more, distinguishing between these as influence being the ability to get someone to do something because they feel it is the correct course of action (Lucas and Baxter, 2012). There were few examples of NEDs blocking executive decisions; instead NEDs appeared to prefer to persuade executive colleagues, drawing on their professional expertise. In considering why this might be so, the public sector context is relevant.

The PCT's autonomy was limited, operating within a hierarchical relationship where executives were also accountable to the SHA. In a delicate balance of power the NEDs competed with the SHA to influence executives, with the coercive power of the SHA to influence behaviour appearing to be stronger than that of the board. It would seem that rather than entering into a conflictual relationship with executives and a potential power struggle, NEDs instead tried to persuade executives as to the rightness of the decision proposed.

The findings presented in this chapter show NEDs contributed to a range of roles. Conformance-oriented examples, such as the monitoring of performance, dominated, which supports the findings of the previous chapter that this was a dominant aspect of the NED role, as expressed by respondents.

However, while this role may be the one respondents chose to emphasise in their accounts, analysis across the range of discussions found that NEDs also played additional roles, in which there was a more collaborative relationship between executives and NEDs. NEDs provided support to executives and shared expertise in a wide range of meetings occurring outside of the board and formal committees, either planned or ad hoc. These saw NEDs able to influence decision making before items came to a formal decision in a board meeting. NEDs also responded to external policy changes by taking on more operational roles as they felt the context required, such as providing business acumen. This greater involvement in the organisation did not appear to impact on the NEDs' ability to then scrutinise management decisions, supporting Roberts *et al*. (2005) that NEDs are able to live with the tension between a conformance and a performance-oriented role.

A key area of interest for this study was how corporate governance in the public sector might differ from that in the private sector. This chapter has shown similar roles in monitoring and strategy as identified in the private sector (Stiles, 2001). There were additional elements, specific to the public sector context, however. NEDs who identified strongly with stakeholders played a particular role in ensuring these interests were represented. This was one way NEDs were able to influence the decisions that had to be made by the PCT board between local and national priorities.

This chapter has focused on NED power, influence and contribution within the PCT. However, PCTs had a multifaceted role, not merely providing health services but also seeking to improve health through a range of relationships with commissioned services and with contractors. This is considered further in the next chapter, which will examine the power of the NEDs on the PCT board with regard to different relationships such as with the SHA, commissioned services, and contractual relationships with primary care practitioners.

Chapter Six. NED power and contribution in relation to wider governance accountabilities

The previous chapter concentrated on the NED role and contribution within the organisation. However, the PCT operated within a complex set of relationships involving a range of stakeholders. When considering NED contribution, analysis showed much of this concerned relationships with key external stakeholders, such as those with which the PCT had a hierarchical accountability, commissioning or contractual arrangements with. These relationships are considered in this chapter as they are an aspect of the role under-investigated in previous studies on NHS governance, which have concentrated on internal relationships. They highlight not only how the practice of corporate governance might be different in the NHS but also how NEDs were able to help the organisation fulfil its function as a local organisation.

The chapter concludes by examining how the NED role changed in response to the changing policy environment once the announcement of the abolition of PCTs was made, with many PCTs moving to arrangements where they shared management with other PCTs. This saw the NED role taking on a different emphasis within the PCT board and, for some NEDs, new roles in relation to the emerging clinical commissioning groups.

6.1 Power and contribution: the NED role in the wider health economy

The previous chapter identified sources of power within the PCT for NEDs as business knowledge, local knowledge, organisational knowledge – which helped balance the information asymmetry between full-time executives and part-time NEDs – and the professional independence of the role. These sources of power were utilised to enable NEDs to contribute to a range of mainly conformance-oriented roles but also performance-oriented ones, with regard to helping develop strategy and providing resources.

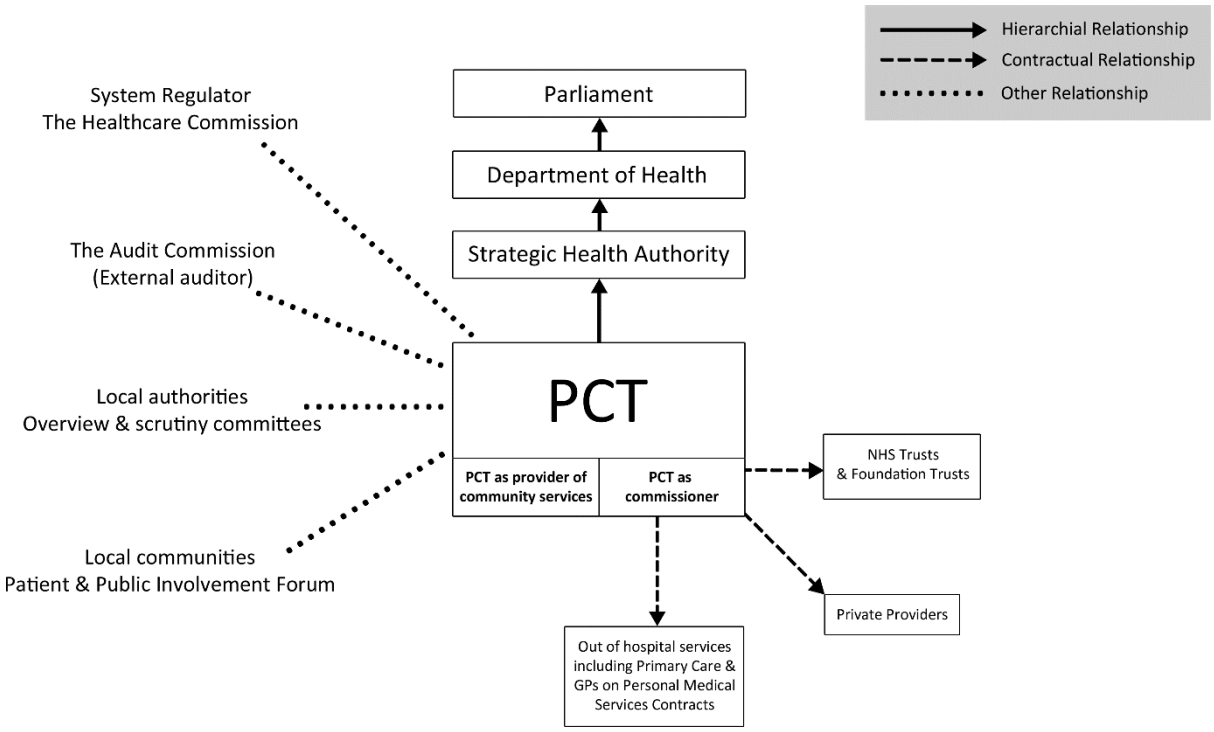
This chapter examines further the outward-looking, performance-oriented role. One role for the board is to help the organisation recognise and respond to changes in its strategic environment (Pfeffer and Salancik, 1978). The findings presented in this chapter show NEDs were able to help the organisation respond to national directives and adapt to changing political and societal expectations. Their own role changed too as NEDs interpreted the external environment and adapted their role in response. Important director skills are identified by Pye (2013, p.151) as the ability to 'read' a situation and then 'wright' a role in response, as in creating something new. This chapter presents ways different NEDs read different situations and crafted what they felt was an appropriate response.

The PCT operated within a complex environment and the board's power, and that of its NEDs, was constrained by the relative power advantage of the SHA and the professional power of local GPs. The power struggles between the board and these stakeholders were a significant theme in analysis.

Sources of power available for NEDs in these wider, external relationships were their desire to act on behalf of and to support local people, their professional independence, relationships with key stakeholders in the health economy, and their ability to build coalitions and networks, as well as their business knowledge and skills.

Figure 6.1, first presented in Chapter One, is shown again here to provide the context for this chapter as this shows the major relationships for the PCT. These included direct accountability to the local SHA and then to the Department of Health, different accountability relationships to various external organisations, and contractual relationships with primary care contractors such as GPs and with commissioned services, such as local hospitals. The PCT was also expected to work collaboratively with citizens, patients and other organisations to improve health and deliver public value.

Figure 6.1: PCT accountability relationships; a flow chart



NED power within hierarchical arrangements

Analysis showed that across all NED accounts the SHA was perceived as acting in ways that were not always in the best interest of local people. As already discussed, the SHA was seen as possessing a major source of power, able to control PCT executives with the threat of sanction, which could be career-limiting, to ensure its objectives were met. This coercive power (French and Raven, 1959) appeared greater than the power base of the NEDs. However, there were a few instances where NEDs had challenged the SHA and influenced the executive to do something differently to what the SHA wanted. These are explored in some detail as they prove an exception to the major theme from this study, that SHAs were the more-dominant power compared to the PCT board.

To return to the analysis of power by Pettigrew and McNulty (1995), NEDs needed to have the motivation to act, along with the skill to utilise different methods of influence within the healthcare system. Here, the motivation to act

arose from the desire to protect the interests of certain stakeholders, whether local patients or, in one example presented, prisoners, where this is threatened by the vested interests of others. However, NEDs needed skilful interpretation of the situation to then determine the actions appropriate in that particular context. Some of the differing responses of NEDs to specific situations are considered next, showing that NEDs did challenge managerial hegemony at times and drew on different sources of power to do so.

Defending patient interests against perceived professional interests

In one large rural PCT in the South-east of England there was a long-term plan to invest in new GP premises within a certain location. However, the outline business case was finalised at a time when the new clinical commissioning groups (CCGs) were being formed and there was opposition from some of the GPs, who were to hold greater power under the new arrangements. The NEDs considered this opposition to be due to the vested interests of the GPs, who wished this investment to be placed elsewhere in the area. The SHA were subsequently reluctant to agree the business case, putting pressure on the PCT executives not to proceed with it.

The NEDs in this PCT cast themselves as championing community need against the structural power of the SHA and the professional power of the GPs. Rather than using methods of influence (Lucas and Baxter, 2012), NEDs used power tactics to try and force the SHA into accepting the board's wish for the business case to proceed and the new premises to be built. These tactics included forming a coalition with residents and organising meetings to gain community support. Local CCG leaders continued to oppose the business case for the new premises and this NED described the NEDs' next actions:

> *But the NEDs were adamant, no, and we called in to a board meeting some of those other CCG, GP leaders, challenged them about their objections, and knocked down all of their objections. And they still wouldn't remove their objections, but we fought it through with the SHA and insisted that this business case be approved and we're going ahead*

> *with it. If you, the SHA turn it down, then that's up to you, but we're not withdrawing it. And it's now proceeding, it's not opened yet, but it's, the building's underway.* NED 35, PCT F.

This confrontational stance taken with the SHA and the language used is quite different to that used by NEDs to describe their actions within the PCT, as discussed in the previous chapter. In this example the business cases for the new premises are finally approved, which the Chair attributes to the contribution of the NEDs:

> *I think it is only the determination of the non-execs to ensure that they actually did get agreed and happen that they are happening.* Chair 30, PCT F.

The independence of the NEDs, not dependent on the SHA for their future career as the executive were, enabled them to take a more risky stand against the authority of the SHA, though it is open to question whether such a stance would have been taken had circumstances been different and PCTs not about to be abolished. In the previous chapter the ability of the SHA to pressure the Chair and NEDs to resign was seen as limiting their autonomy and ability to challenge the SHA.

Defending stakeholder interests against perceived managerial interests

An additional responsibility for PCTs was to provide primary healthcare services within prisons. However, they were not responsible for the facilities within which the services were provided and, in one PCT in the South-west of England, the prison facilities were considered to be of poor quality, unsuitable for the provision of health services. The NEDs' 'reading' of the situation and the actions required led to an inspection visit by NEDs, after which it was decided the ongoing provision of services could not be supported. This decision and the communication of their intentions and concerns to various authorities, including Government departments, led to a new medical facility being built. This was identified by the Chair as a major NED contribution and their professional

independence from the PCT a significant source of power, with the executive too concerned for their own professional future to take such a confrontational stand.

The findings of this study show NEDs helped their PCTs respond to external pressures impacting on its ability to provide healthcare to all areas of its population. NEDs utilised networks within local communities and access to key personnel, in a route not open to executive directors. Supporting resource-dependency theory (Pfeffer and Salancik, 1978), NEDs acted as boundary spanners, connecting the organisation to its strategic environment and significant stakeholders. There was no financial motivation for NEDs to take on the additional work involved, such as attending community meetings, nor did these necessarily contribute towards the PCT's achievement of its performance indicators.

So this poses a question as to what influenced NEDs to 'read' a situation in a particular way and respond as they did. Would all NEDs have responded similarly? The analysis presented in Chapter Four suggests that one influence might be the salience of a public service and stakeholder identity. NEDs in these PCTs strongly identified with the values associated with public service and the desire to promote and protect the interests of stakeholders.

In these two examples NEDs proactively tried to influence decisions that needed agreement from external partners. In other accounts, examples given were of centrally-imposed policies where NEDs tried to reactively influence executives to modify these so as to better meet the perceived needs of the local area. A source of power was the local relationships NEDs were able to draw upon.

Challenging national policy directives: Darzi centres

An example given by six different respondents, NEDs and Chairs, in different PCTs, of NED contribution was their response to the policy to extend GP practices' opening hours, a recommendation by the then Health Minister Lord Darzi in his Next Stage Review of the National Health Service (2008). The Government ordered that each PCT should have a health centre (sometimes

referred to as a Darzi centre) that was open 12 hours a day, seven days a week for patients to see a GP.

It has previously been identified that NEDs had a gatekeeper role in strategy development, ensuring proposals were in line with the values of the board, supporting a finding by Stiles (2001) from the private sector. This aspect of the role comes to the fore here, with NEDs in some PCTs concerned that this centrally-imposed policy to create a Darzi centre was overly prescriptive, with improved GP access for patients able to be achieved in more locally-appropriate ways. These proposals were initially rejected by NEDs in these PCTs as not serving patient and local interest, in line with the organisation's objectives. The following excerpt is from a NED in a North-east England PCT, a previous finance director:

> *As I say, the executives were very much pushing to just follow a timetable, there's the instruction… And the non-executives collectively said, no, no you're missing the point, we want to make sure that whatever we do does, fits one of our major objectives which is to do something about the deprivation and the relief of deprivation and inequalities.* NED 33, PCT P.

In this PCT a source of power for NEDs was relationships with key stakeholders within the health economy. The NEDs drew upon support of local GPs and a long-term relationship with the local hospital trust board to reject the initial timetable imposed by the SHA. The delay in implementation enabled the centre to be built in a particular area of deprivation that fitted into wider strategic plans regarding services at the local acute hospital.

The relationship in this example appeared less adversarial than in the first example in this chapter regarding primary care premises. Here, the NEDs were able to bring together different parties to persuade them as to the benefits of their proposals as it built upon relationships rather than forming a coalition to bring particular pressure to bear on one party. It shows how NEDs were able to utilise networks and relationships to help the organisation adapt and respond to external policy requirements in ways that were locally appropriate.

In analysis of the examples given of NED contribution one particular source of power was this successful mobilisation of relationships with key stakeholders, whether patients, GPs or other organisations. From analysis of the interviews with other NEDs who tried to modify the directive to have a Darzi centre, they appeared to lack the support of these key relationships. Where PCTs did try to provide the access requirements for GPs in a different way to what the policy proposed, the use of sanctions in the form of failed performance indicators, forced them to comply with the national policy, as in this example from a PCT in the North-west of England:

> *… but no that didn't meet the guidance, which guidance means diktat, and we were the only particular primary care trust that year who were rag-rated red for not having achieved their targets on extended hours, when we were offering our population better than what they were asking for, so that showed to me that innovation… there's no point being innovative because ultimately you're told what to do and we were forced to correct what we did within months.* Chair 40, PCT T.

The use of national targets to curtail local autonomy supports the findings of Exworthy *et al*. (2010). It also supports Newman's (2001) view that while the Government may have appeared to have relinquished some direct control, such as creating PCTs as freestanding organisations, it enhanced its capacity to extend influence and control by drawing in a range of actors including the Healthcare Commission, who assessed health organisations against national targets and published the results. The resulting media coverage and SHA pressure on Trusts meant that many PCT boards experienced the 'targets-and-terror' (Bevan and Hood, 2006) regime and felt pressured to conform.

The Darzi centre was one central initiative that caused tensions for NEDs on PCT boards in trying to implement the aims of a policy but not necessarily in the prescribed way. Another central initiative identified as a particular area of tension and NED contribution was the requirement for PCTs to cease direct provision of community health services.

Community services

In 2005 the Department of Health issued a directive for PCTs to cease direct provision of community services such as health visiting and school nurses, and to concentrate on their commissioning function (DH, 2005). A later White Paper (DH, 2009) suggested different modes of alternative provision for the PCT to consider and decide upon the best option for their area, such as the community services becoming a social enterprise or joining with an acute trust. Many respondents in this study saw this as a centrally-driven policy with an unrealistic timetable for implementation, with SHAs setting deadlines for PCT proposals to be finalised, ready for a Government deadline of transfer of services by April 2011.

From analysis of interviews across eight different PCTs, the NED's role in defending the local/patient interest is a strong theme. NEDs took on a gatekeeping role with regards to the proposed transfer of community services, assessing proposals from managers to ensure they were in line with the values of the PCT and the interests of the local people. The centrally-imposed timetable, which meant there was insufficient time for the board to explore what might be the best option for the area, was one concern, as for this London NED, discussing the proposed transfer of community services to a local acute trust:

> *…I think we probably put the brakes slightly on the decision making because we really, really wanted to think that through and we… the specifics of it, and we spent a lot of time on articulating the benefits that we wanted to see realised from the transfer. And we… pushed for, and got a board to board with the (acute trust) board. I wouldn't, I'm not saying the executive were resisting that, but… it was something that came from us and I think that, that approach and level of expectation, we added something there, when it might have gone through in a more kind of prosaically operational, how do we deal with this kind of way.* NED 6, PCT L4.

NEDs were not only able to challenge the implementation timetable and insist on more time but also, in some cases, to insist on changes. In two PCTs NEDs' scrutiny of proposals for the community services to become social enterprises led to demands for further information, in one example halting the process and insisting on a different proposal. This was the same PCT in the South-east of England where NEDs resisted plans to alter a business case for new GP premises, seen at the beginning of this chapter. The NEDs also halted executive plans for the community services, as the Chair explained:

> *There was a proposal which was entirely opposed by all the staff of our provider services to become a social enterprise. There was a great deal of rule by the executive that you should become a social enterprise against the wishes of all the staff. Because of the non-executive view that the staff are the people who provide the service, and if they are not happy, that is the wrong road to go down, it didn't happen. ... So I think our challenge ensured that that, that a different decision was made, was taken.* Chair 30, PCT F.

The exercise of power is considered a dynamic process, where actions in the past influence the context for the exercise of power in the future (Giddens, 1979). As will be examined further when considering the role of the Chair, in some PCTs a history of successful actions by NEDs and Chairs led to greater power in future encounters, as appeared to be the case in this PCT.

While business knowledge and the assertiveness drawn from this were the main sources of power and influence, local knowledge and networks also enabled NEDs to influence the future of community services provision. In a London PCT NEDs drew on their knowledge of local patient pathways to influence a decision that the acquisition of the community services by the hospital would best meet the interests of patients in the borough. The disinvestment of the community services and the exploration of new ways for these services to be provided called for a level of business knowledge, such as of procurement processes, that many PCTs were felt ill-equipped to deal with. As such, the specific governance and business knowledge NEDs were able to

bring was a significant resource to the PCT and enabled many NEDs to make what they saw as a significant contribution to the process.

There was greater success for PCT NEDs in challenging a timetable for national policy implementation than in whether or not that policy was to be implemented. One London PCT wished to continue providing community services but, while the original policy directive was modified so this was a possibility, in practice the PCT received pressure from the SHA to cease direct provision and the community services were eventually transferred to another provider.

PCTs and the SHA: constrained financial freedom

The PCT received an annual financial allocation from the Department of Health based on a number of factors, including size of the population and levels of deprivation. The Operating Framework for the NHS (DH, 2010b) required each board to have a financial plan that would ensure the organisation broke even each year, with the SHA acting to ensure that NHS organisations in its area met this obligation.

This pressure led to an emphasis within PCTs on financial management and a strong compliance and monitoring role for NEDs with financial backgrounds. It also led to possible tensions across the health economy, which again saw the NED act in a role to protect local interests.

An issue seen by many NEDs as constraining their autonomy as a board and limiting their ability to act in the best interests of the local community was when the SHA demanded PCTs contribute financially to other NHS Trusts in the region to enable them to break even. This was considered to be unfair and disruptive to the PCTs' own financial planning. In one SHA area in the North of England a number of PCTs who commissioned care from (X) hospital Trust were requested by the SHA to give financial assistance to the hospital, which had been in financial difficulties for several years. The SHA was under pressure from the DH to ensure the hospital broke even, which required the local PCTs to agree £14 million of in-year funding to (X) hospital.

This request provoked a tension between the managers and the NEDs in local PCTs, who are perceived as serving different interests. The managers are seen as working for the interests of the SHA, responsible for all NHS Trusts in the area, rather than for the local PCT. The NEDs are concerned to protect stakeholder interests but the reasons for the concern vary and appear influenced by NEDs' background and the salience of difference identities, as discussed in Chapter Four. For the Chair of audit at one of the local PCTs and a previous local authority accountant, his concerns were of efficiency:

> *Everyone seems to try to be complicit in keeping the system on the road and, and, not allowing the hospital to fail… And we as non-executives I think have got to the stage where we're saying actually for the benefit of the people we are serving, it'd be better if the balloon went up. Not that you stop providing services to people because you'd find a way to do that, but you know some... the system claims to weed out failure but it doesn't.*
>
> *I think in this particular instance, actually the non-execs are the ones who are being first of all, objective and also strategic because we're starting to say we've done this, it hasn't worked, it's been done twice before. You need a radical solution to all of this and the worst thing we can do is bow to pressure from… on high because that's not, that won't do anybody any good in the long term.* NED 20, PCT W.

A fellow NED who worked for a local authority, while concerned about efficiency, was also particularly concerned about protecting the interests of local people. The hospital is sited at the edge of the PCT boundary and his concern was that by concentrating resources there, the rest of the population was disadvantaged. This was also a concern of another NED who saw herself as representing stakeholder interests, with a strong concern for public health. A further concern for her was that the financial contribution would mean that the longer-term investment in health improvement projects the PCT had planned would be cut. Her report exemplifies resistance and 'answering back to power', as in the following description of the board's conversation with the SHA:

> *There was, I would say, a certain extent bullying that you will toe the line.*

> *Well, we at the board feel this is not right for us, for our people of (…) etc., etc. Yes, but you are part of a wider health economy and you have a responsibility and we would suggest this contribution to the financial position would be useful.* NED 15, PCT W.

The performance report of the SHA at the time of the interviews (Health Services Journal, November 2011) reflects the position of the NEDs, stating that the PCTs require (X) hospital to meet its own internal financial and performance targets before they will agree any external funding. The health secretary at the time is also involved, ordering the SHA to sort out the problem of this particular hospital. Against such power, the ability of the NEDs to resist the SHA's directives or to fight for local interests appear limited. An SHA board finance report a year later indicates that the PCTs had not only agreed financial assistance, but were also providing further funding as the hospital tried to meet financial targets that would allow it to apply for NHS Foundation Trust status.

This example illustrates the dilemmas experienced by NEDs as they sought to balance the health needs of local communities with the requirement to give financial assistance to the wider health economy. Other PCT areas with hospitals in financial deficit faced similar challenges. Acting in a representative role could be a difficult one for NEDs, with possible conflicts between representing a particular geographical area or a broader interest, such as all the patients served by the hospital.

The top-slicing of budgets

Further tensions around finance and how interests were defined and defended were seen in analysis of the accounts of London PCT NEDs and Chairs. Just before the interviews took place all 31 London PCTs were required to top-slice their annual financial allocation to assist those PCTs and trusts that were struggling financially, so that across London all organisations achieved financial balance. A dilemma for some NEDs was whether their allegiance was to the local community served by the PCT, which would lead them to resist the calls to share finance, or whether they were serving the broader public interest of the

wider community, in this case London. This London NED expressed her frustration:

> *I think the most frustrating thing for me coming from a local authority background where you know you get your budget at the beginning of the year and you know that's the money you've got to work with. I think being in an NHS environment where you know you set a budget, it was balanced, you think the organisation's on the way up and then, you know, you will be top-sliced and have to provide several million pounds to challenged trusts across London.* NED 21, PCT L11.

However, whatever the views of NEDs and Chairs, the finding across all accounts was that when it came to SHA requests to give financial assistance across the health economy, the PCT board had less power than the SHA and always ceded to the request. Dissatisfaction with the SHA and feelings of disempowerment are a theme in the accounts of some London NEDs and Chairs, particularly from PCTs who served poorer communities and had to assist trusts in more affluent parts of London.

The next section considers another relationship regarded as challenging, the role of the PCT in managing primary care provision.

Power within contractual arrangements: PCT NEDs and primary care

PCTs were responsible for the provision of primary care services delivered by GPs, dentists, pharmacists and opticians. These professionals were not employed by the PCT but operated as independent contractors. There were two types of contract for GPs, a nationally-determined one and a locally-determined one. The latter was between the PCT and GPs and, in areas where these contractual arrangements were in place, contract renegotiations – seen by PCTs as creating better value for money but which could lead to some reductions in practice income – were bitterly contested by GPs. Managerial interference in what were seen as professional matters was resented and NEDs

had a key role in supporting the executive team in taking difficult decisions, as this Chair from a North-east PCT explained:

> *When we were... renegotiating GPs' contracts in one of our areas, it was very, it was really good that non-execs were able to get an understanding of that, and help the board, because that was, that was really difficult, some of the GPs quite frankly were really horrible so it was very useful to have non-execs helping in that role and you know being supportive of the particular executives who were under, under threat really, from GPs.* Chair 47, PCT Q.

In this respect, NEDs on PCT boards appeared to support Williamson's (2008) view that they were corporate rationalisers, unsympathetic to the needs of patients and health professionals. However, rather than seeing these two sets of interests as aligned, this study showed that patient interests were championed against what was seen as professional self-interest, although the power of the NEDs in this matter varied. When it came to contract negotiation then the PCT board had structural authority and legitimate power (French and Raven, 1959) to draw upon – even if this was resented.

If there were substantial concerns about the performance of an individual GP then there was also a clearly-identified route by which this could be addressed, both at a PCT and a regulatory level. PCTs had responsibility for maintaining a list of GPs able to practice in their area, and, in many areas, NEDs sat on panels considering the performance of GPs where concerns had been raised. These panels could decide if the GP should be removed from the practitioners' list.

However, where a GP practice provided a substandard service, such as poor facilities or limited screening of patients for disease risk factors, then this was seen as much harder for the PCT board to address and brought it into conflict with the GPs and the local medical committee. This London NED, a retired social worker in a PCT where there were widespread health inequalities, voiced her concerns:

> *What I haven't mentioned are GPs actually, I suppose that was more, I*

> *did find it very frustrating, difficulties of, I suppose, really monitoring and regulating GPs, I thought we were only just beginning to get to grips with it and although there was some excellent and very professional GPs who provided a wonderful service, in most areas it was quite variable and there was some very poorly-performing GPs and it was the frustration really… We weren't able to deal with that in the time that the PCT was in existence really.* NED 4, PCT L5.

The most concerns about GP practices arose from London PCTs. In two different London PCTs NEDs took an active role in defending the patient interest and insisting that concerns were addressed, in one case bringing GP practices under direct PCT control. Some of the difficulties faced were felt to be due to the historical reluctance to deal with poor performance by GP practices. NEDs perceived that managers were reluctant to confront professional resistance to managerial involvement in professional matters. The PCT was also dependent on GPs to help it meet a number of performance targets, such as reducing hospital admissions, so needed to work collaboratively with them in network-like arrangements and not just through contractual routes, demonstrating the limitations of NPM approaches (Osborne, 2006).

The GP performance panels referred to give an example of the range of activities that some NEDs became involved in to represent a lay interest, free from any perceived conflict of interest. For a few NEDs this involvement in performance panels was identified as a major contribution they had made in their NED role. This more operational involvement in the PCT demonstrates how the role in the NHS varied in how it was conceptualised and enacted, compared to the private sector. In one PCT a Chair stopped the NEDs from being involved in these types of activities so as to concentrate on their governance role and instead recruited a panel of lay members to be involved, but this was an isolated example.

The next section considers the relationship of the PCT to those it commissioned care from, in particular the local hospitals that provided secondary care.

Power within commissioning relationships: PCT NEDs and secondary care

PCTs were responsible for commissioning secondary-care services for their population. When PCTs were first created there was little understanding of commissioning; they were required simply to purchase care for their population usually via a block contract with a local NHS provider. An emphasis on commissioning developed, particularly following the publication of '*Commissioning a patient-led NHS*' (Crisp, 2005). The changing policy environment led NEDs to develop new roles in response, providing another example of how their 'reading' of a situation led to the 'wrighting' or creation of a new role (Pye, 2013). Different roles evolved in different areas, showing that the 'reading' of a situation and the response was influenced by the local context, the individual NED's interpretation of the situation and, in particular, the lead taken by the Chair.

As already identified, there was a duty on the PCT board to achieve financial balance. This was challenged by a number of factors largely outside of the board's control. These included the introduction of policies that gave patients a choice of where they received care and a payment mechanism that meant the money followed the patient, with PCTs later billed for the care provided, but with no approval needed in advance as is the case for private healthcare.

The financial impact for a PCT if its main provider Trust charged more than had been allocated in the PCT budget led to some NEDs becoming closely involved in monitoring the financial aspects of the contracts with the acute trusts, as this Chair from a PCT in the South-east of England explained:

> *… a few years ago, I felt that we couldn't do very much about overspend on big providers, as non-execs, what's happening now is the non-execs are actually making things happen in terms of performance, in terms of reviewing, in terms of analysing in more detail. So what they've been doing is analysing what I call the day job, in a much more detailed way and working with… to find out where the problems are. So the demand*

on money has got stronger and stronger and therefore the non-execs have had to react to that particular issue. Chair 13, PCT G.

The private sector focus NEDs brought, around what another Chair called '*balancing the bottom line',* was a strength that executives in the NHS, less familiar with contract management, were considered to lack. This gives further support for resource dependency theory (Pfeffer and Salancik, 1978), with the recruitment of NEDs with particular business skills able to help the PCT respond to an external threat. While NEDs would not have traditionally been involved in this level of scrutiny of a commissioned service, the role evolved in response to the perceived need.

Scrutinising quality

The evolving role of the NED in response to the external environment was even more apparent when considering the NED role in ensuring the quality of care within hospitals. Although the Government had set up a quality regulator, the Healthcare Commission (later to become the Care Quality Commission), there was also an expectation that PCTs as commissioners would ensure high standards of quality and enforce these through the contractual route. This expectation was made more explicit following independent inquiries into care at Mid-Staffordshire NHS Foundation Trust (Healthcare Commission, 2009), which would later give rise to a full public inquiry.

As already identified, one group of NEDs had a particularly salient stakeholder identification. Within this group a particular contribution to governance was seen as ensuring the quality of care was at the forefront of the board's attention and by involvement in quality-related tasks such as chairing quality committees. The area of interest here is how NEDs extended their role, in response to both public expectations and a greater policy emphasis on commissioner responsibilities, to take a more proactive role in addressing quality issues in the hospitals from which the PCT commissioned care.

These proactive steps included initiating a system of NED quality assurance visits to providers of patient care such as the local hospital, as in this example from a North-east PCT by a NED with a background in corporate governance:

> *In terms of integrated governance I feel that we have been able to make some changes, for example we've set up a visit, a system of visits for patient safety, so we have non-execs going out and looking at those organisations and how they're working.* NED 44, PCT Q.

The findings of these visits would report to the quality committee. While not specified in the appointment specification (Appointments Commission, 2006) or in any of the guidance for PCT boards, the NED 'walk around' is recommended for board members of provider trusts (National Leadership Council, 2010) and it appears its extension to NEDs in PCTs was locally-initiated, only appearing in some accounts. This monitoring role could appear to overlap with a management role and, in a couple of accounts, NEDs reported that new executives joining those PCTs that carried out these visits questioned the NED involvement.

When considering how the NED role in the public sector is different to that within the private sector, it can be seen that the performance-oriented roles within the public sector are less clear-cut. The commissioning of services includes a mix of performance-oriented roles as well as conformance. Societal expectations are another important factor, which Pettigrew and McNulty (1995) saw as guiding the actions of the NED and how they understood their role. As public attention focused on the quality of NHS care and held PCT boards to account as the commissioners of care, it appears some NEDs did not wish to delegate this aspect of responsibility to executives but preferred to take it on themselves or were allocated it by the PCT. In one example of NEDs' taking on an increasingly-operational role, the NED Chair of the quality committee not only visited provider trusts but was also 'on call' for the chief executive to call out of hours should a quality issue arise at a local hospital.

The PCT board; limited autonomy

While a focus of this study has been on the contribution of NEDs, addressing a lack of such studies in the NHS, it has also highlighted areas where NEDs saw their power and ability to contribute as limited.

As seen in this chapter, the power of the PCT board was perceived as limited by the greater power of other players in the system, whether the NHS Foundation Trusts, who could bill the PCT for costs beyond that which were planned for, the GPs who used professional power to resist attempts to improve primary care, or the SHA. The latter was seen as the greatest barrier to PCT boards having the freedom to act as they saw in the best interests of the local population. As previous sections have shown, managerial hegemony appeared at its strongest when it came to issues of finance, when directors within the SHA were able to insist on PCTs sharing their budgets with other trusts. There was limited freedom in other aspects too, such as how policies were implemented, as this NED from the North-west of England explained:

> *The SHAs – it's like a backseat driver, you know for me, certainly when we had engagement with the GPs we did a massive consultation, I think we were the only PCT in England that were going down the proposal that we should have, a polyclinic effectively, you know one of these super centres and so the proposals went out to consultation and all the GPs turn- turned against it and so we wanted to exercise that – but of course we couldn't because the SHA's saying, "No you have to do this, you have to do that." How can you run a business with someone whispering in your ear half the time?* NED 43, PCT U.

The behaviour of the SHA, and its influence on the PCT, was seen by a retired finance director, now a NED in the North-east of England, as a crucial difference to corporate governance in the private sector:

> *So it's an interesting governance thing. I suppose the thing is you begin to realise that, compared to the private sector is, that… the boards are*

actually set up legally as independent organisations and you can use that situation from time to time but equally from a governance point of view SHAs in particular like to act and indeed the Department of Health but as I say the Strategic Health Authority like to act as head office as if they're your shareholder. NED 33, PCT P.

While NEDs may have had power within the board and organisation, as examined in the previous chapter, it was the wider power networks within which the PCT was situated that were felt to limit the role although, as this chapter first set out, this was successfully challenged by some.

This tension between being part of a national system with national accountability, yet trying to work within those constraints to exercise local autonomy and accountability, presents one of the key differences to the practice of corporate governance in the public sector. It is explored further when examining the role of the Chair and the tensions inherent in a system that incorporates differing governance models and relationships. Not all the Chairs perceived the SHA in as negative light as NEDs did, which may reflect the greater power they had within the system.

The negative perceptions of the SHA, held to blame by NEDs for failures to achieve the original aspirations of PCTs as local organisations, may well reflect the particular context at the time of the interviews. However, a finding of curtailed local autonomy due to strong vertical control is similar to that from previous studies in the NHS (Abbott *et al*., 2008; Exworthy *et al*., 2010).

Section summary

This section examined the role NEDs played with regard to relationships between the PCT board and those organisations with which it had a hierarchical, commissioning or contractual relationship. Power sources for NEDs included their professional independence, relationships with key stakeholders, and their ability to build coalitions and networks, as well as their business knowledge and skills. However, power is relational and while NEDs

reported instances where they had had power to contribute, sometimes their power was constrained by other actors, such as the SHA or GPs.

One theme presented was how NEDs adapted their role in response to their reading of different local situations. The NED role in reading different situations and then responding (Pye, 2013) led NEDs in some areas to adapt their role, taking on greater operational involvement in the monitoring of finance and quality in commissioned services. The attention of NEDs to issues of quality of care was seen as particularly needed at the time of the interviews, with a perceived risk that during the time of transition to new structures such as clinical commissioning groups (CCGs), the monitoring of performance could be reduced. This next section examines how the emphasis of the governance role changed following the Coalition Government's announcement of the abolition of PCTs and the transition to CCGs.

6.2 Transitional arrangements and impact on role

This section examines how the NED role changed as a result of the move to working in PCT clusters, with shared management teams, as detailed in Chapter One. While the directive to cluster was a national one, there was limited national guidance as to how the board or NED role might differ in this time of transition. There are no previous studies that have examined how the board of a public sector organisation might respond to notice of its abolition or how the role of board members might change during a period of transferring its functions to new organisations.

The dynamic role of an 'effective' NED, able to read different situations and respond accordingly, was highlighted by Pye (2013). This study found NEDs 'read' this period of transition as one of risk to the organisation, but more particularly a risk to the interests of government or local patients, with the emphasis varying across the country. In response, NEDs' role on PCT boards changed in their emphasis and new roles were assumed in relation to CCGs.

The PCT organisational role is considered first.

The NED role on the PCT cluster board

The emphasis of the NED role within the PCT changed in this time of transition. While Chapter Four showed that the monitoring of performance was identified as a major part of the role, this received greater prominence. NEDs' and Chairs' reading of the situation and the risks presented during this period of transition, with executive directors concerned for their future career, saw them assuming a key role in ensuring that financial performance, and the safety and quality of services did not slip. This was sometimes referred to as keeping a '*grip*' or '*trying to keep the show on the road'* within the context of changing Government policy. The strategic aspect of the role largely disappeared as CCGs took greater responsibility for local strategy.

The increased size of boards serving clusters of PCTs and the reduced time available within a board meeting, due to the increased number of items on the agenda, meant the dynamics of board relationships changed. Too much challenge and critical debate were considered inappropriate with the necessity of implementing a centrally-imposed tight timetable of transition. As one London NED put it:

> *But, but right now what's got to happen and what's being required to happen and at speed, means there is less room, both in sort of time and wriggle room for challenge I think.* NED 6, PCT L4.

While the control element of the role was the predominant one, the contribution of particular skills was also seen as important, particularly in London. NEDs who had business skills were able to contribute their knowledge to the design and development of the new Commissioning Support Units, which were to provide commissioning support to CCGs. London appeared ahead of the rest of England in establishing these, so, while mentioned by London NEDs, they do not feature in other accounts.

A key theme that arose from the accounts of London NEDs was that the role of the NED in this time of transition went beyond a governance role but included an active contribution of particular experience to help a management process. Although the conformance-oriented roles (Tricker, 2015) were still very much in play, particularly in relation to the scrutiny of performance, NEDs took on more operational roles in this time of top-down change in a way that was different to the role in the private sector or envisaged in guidance (Appointments Commission, 2006). It reflects the particular context when PCTs were expected to act in a more commercial way but executives were seen as lacking the skills NEDs could bring from the private sector.

National or local interest?

An area of interest for this study has been the tension between serving local interests or national ones. In this time of transition, differences between areas of the country were apparent.

The London SHA (NHS London) had a strong influence on the PCTs in London. Whereas in other areas of England training sessions for NEDs ceased once the abolition of PCTs was announced, NHS London organised three workshops for NEDs. The first in November 2011 took place around the time of the interviews. In the invite letter (31 October, 2011) the Chair of NHS London sets out the purpose of the workshops as 'to identify ways we can work together to ensure the Government's programme of reform succeeds in its objectives'. This places the principal as the Government, with the NED role to ensure these interests are protected and promoted. This view is reflected in the accounts of the London NEDs, with an emphasis on the organisational role and the greater operational involvement to ensure that tight deadlines are achieved.

In PCTs in the rest of England the emphasis on safety and financial performance was similar to those in London. However, the interests to be protected were more overtly the patients and local public, rather than the Government's interests in controlling performance and expenditure, as was the case in London. The NED role is as a mediator of national policy and how it is implemented locally, ensuring that local interest is protected. The following

excerpts from interviews with two different NEDs, both with business backgrounds and serving in PCTs in different parts of England, are their responses to a question as to how they saw the NED role at the current time, with the transition of functions from PCTs to CCGs:

> *(The role is) moving the NHS through transition from one system to another as safely as possible so that patients and the public don't actually realise that something's happened.* NED 33, PCT P.

> *(It's to) ensure there is a smooth transition, to ensure the only thing that changes is the governance and the way it's, and the way the governance is administered, so that so that at its very worst, our patients see no difference and as it gets better from that they see improvements. I mean it would be awful if, if they saw a degrading of the service.* NED 25, PCT G.

This aspect of the NED role as a 'defender' of local interest and ensuring that the transition of functions has the minimum disruption for patients is one that particularly came to the fore in this time of great organisational change, and is a quite different conception to the role in the private sector.

This role in ensuring performance and protecting patients' interest was predominant in areas where PCTs had clustered. In the few areas where PCTs had not clustered NEDs instead saw their role diminishing as the CCGs took on more responsibility. However, in areas where several PCTs had clustered the risk to performance increased due to the larger scale of the business, the introduction of a shared management team and the process of change.

NEDs in these clustered PCTs reported an increased workload due to having fewer NEDs for each PCT, as well as additional responsibilities for some on the developing CCGs. A motivation to continue in the role appears to be the values associated with the NED role and their desire to protect patient and local stakeholder interests during this time of transition, with a dominant theme from analysis that the safety and quality of services should not diminish.

New roles for NEDs within CCGs

The previous section examined the role of NEDs on the PCT or cluster board. In addition NEDs in the majority of PCTs (86%) in this study were assigned roles within the developing CCGs. Practice varied, with some PCTs allocating CCG roles to those NEDs unsuccessful in gaining a place on the cluster board, whereas in other areas the same NED sat on both the PCT cluster board and the shadow CCG. Analysis showed two roles for the NEDs in relation to CCGs, providing continuity and an educational role around good governance.

The role of the NED was seen as important in providing continuity during the period of transition, with many managers moving to new jobs before the abolition of PCTs. NEDs were able to ensure organisational memories were not lost but passed on to the new organisations. This was mentioned particularly in the context of finance, acknowledging that CCGs would continue to face many of the same financial challenges that PCTs had, as in the following excerpt from a NED in Central England with a social services background, when asked how he saw his role in this period of transition:

> *But the crucial role of the NED is to remember the history of the discussions that you had when you had those financial challenges yourself, and sharing the ideas about what you did or didn't do, so that you just don't reinvent what you tried two or three years ago, for example, around commissioning acute services, or looking at secondary care, or whatever.* NED 27, PCT N.

Just over half of respondents (52%), both NEDs and Chairs, were concerned that GPs were not always aware of governance issues when it came to setting up the CCG. Across the interviews a major theme identified was the educational role NEDs played in either explaining governance issues or modelling good governance within the CCG. The NEDs who sat on CCG governing bodies saw a crucial role in helping ensure that processes were open and transparent. The handling of potential conflicts of interest, which might arise for GPs on the board wishing to provide services to be commissioned by the CCG, was one area of concern and where NEDs saw an educational role, as this London NED

explained when discussing a pathfinder consortium of GPs that would become the CCG:

> *…and the trouble is they tend to get a bit carried away with themselves, and they are somewhat inexperienced still so… and they don't really understand issues like conflicts of interest which they need to get to grips with before they take over as a proper consortium, this is GPs and I think that is something that we are acting as a… a steadying hand really to make sure they don't go off the rails.* NED 9, PCT L8.

In addition to sharing their experience of governance, NEDs also saw a role in modelling good governance, such as how challenge was brought into discussions at the CCG board. Of interest here is the role NEDs assumed in curbing professional power. The role of challenge and accountability was an important one to NEDs and within their accounts they saw it as important that this was brought into the largely professionally-led CCGs. This would give some support to the view of Williamson (Hogg and Williamson, 2001; Williamson, 2008) that those NEDs from business backgrounds were likely to support challenging interests against perceived professional self-interest. However, the concern was widespread across all respondents, not just those with business backgrounds.

Section summary

This section presented findings on changes to the NED role following the announcement of the abolition of PCTs. It considered how the role was responsive to context and, at a time of top-down organisational change, differed to a NED role in the private sector. An overarching role at this time was as a defender of patient interests when these might be at risk, with an increased emphasis on the monitoring of performance, both financial and the quality of care. This was seen as particularly important where distractions of transition and the executives' personal concerns regarding their future career might cause performance to slip.

New roles NEDs assumed were within CCGs where they provided education as to the practice of good governance and particularly how conflicts of interest were to be handled. NEDs also took on a role of providing continuity, passing on corporate memory, as executive directors moved to other parts of the system.

Chapter conclusions

Power is relational and throughout this chapter the power of the NED and his or her ability to influence is examined in relation to other actors in the health and social care economy.

The chapter began by examining the role of the NED in differing external relationships. While the hierarchical arrangement with the SHA was felt to be the dominant accountability, which disempowered NEDs, respondents gave examples where they had defied the SHA. The example that began this chapter, of the PCT NEDs challenging the SHA and local GPs as to the location of new premises, shows they *could* utilise sources of power against these dominant interests. The NEDs took a confrontational stand with the SHA to see through a plan the NEDs saw as being in the best interests of the local community. NEDs within the NHS have previously been found to lack power or a clear role (Veronesi and Keasey, 2010, 2012) but here they took on a role as a defender of patient interests and actively sought and utilised sources of power, through the building of coalitions and their professional independence.

The changing context, with both PCTs and SHAs to be abolished, may have been a factor that led NEDs to seize the initiative and proactively champion their particular cause. This chapter has illustrated how the utilisation of power is a dynamic one, dependent on context but also the actions of actors in changing that context.

As discussed, Giddens (1979) contends that structures cannot be separated from agency, it is the actions of agents that lead to the production and reproduction of structural characteristics of society (p. 257). With PCTs now abolished, perhaps the question could be asked, ‘What if?’ What if many PCTs

had refused to extend access to primary care by creating a Darzi centre but insisted on alternative arrangements, would this positive exercise of power have influenced the relationship with the SHA for the next encounter or have been able to change national policy? However, the majority of NEDs and PCT boards chose not to challenge the authority of the SHA, for fear of its sanction, so reinforcing the latter's dominance over the PCT's board. This confirms the findings of Exworthy *et al.* (2010, p.171) that PCTs did not always exercise the local autonomy that *was* available due to factors such as risk-averse behaviours, although the concerns of NEDs with regards to the Darzi centres were later confirmed. When the new coalition Government was elected, the requirement for each PCT to have a Darzi centre was dropped, with the new health secretary promising instead that each area could make its own more locally-appropriate arrangements (Ireland, 2010).

This chapter has highlighted the dynamic nature of the NED role. To return to Pye's (2013) identification of the three 'R's of corporate directing, the reading of a situation, 'wrighting' as in creating something new, and relating, this chapter has identified how NEDs 'read' different situations and a differing policy context to create new roles, such as scrutinising expenditure by acute trusts and carrying out inspection visits. These more operational roles differ to NED roles found in the private sector (Petrovic, 2008) and demonstrate not only a difference between the two sectors but also how the NED role in the NHS evolved as the policy context and societal expectations of the public sector board changed.

In the face of top-down change brought about by the announcement of the abolition of PCTs, the NED role in defending the patient and community interest was emphasised. Further new roles emerged, with NEDs acting as holders of organisational memory, providing continuity and educating the new CCGs around good governance.

The next chapter examines the role of the PCT Chair over and above their role as a NED.

Chapter Seven. The role of the PCT Chair

PCT Chairs were leaders of the organisation, along with the CEO and the Chair of the Professional Executive Committee, often referred to informally as the 'three at the top'. Their appointment depended on the demonstration of competencies derived from the NHS Leadership Qualities Framework, as well as a patient and community focus and the ability to provide strategic direction. Candidates were expected to bring a significant portfolio of business skills as well as experience of building alliances with a range of stakeholders (Alban-Metcalfe *et al.,* 2010).

The focus of the Chair role was therefore substantially different to that of a NED and this chapter explores this leadership aspect. The first section focuses on the role of the Chair within the PCT before examining their external role across the local health economy and, in particular, a mediating role between the PCT and the Strategic Health Authority. The final section considers the role of the Chair in the period of top-down organisational change brought about once the abolition of PCTs was announced by the Coalition Government.

7.1 Leader of the PCT board

This study, which included interviews with 21 PCT Chairs, confirmed the importance of the role of the Chair in leading the board and enabling debate and contribution from NEDs, supporting findings from the private sector (Roberts, 2002; Kakabadse *et al.,* 2006) and the NHS (Endacott *et al.,* 2013). Themes identified from analysis were roles the Chair played in structuring the board, developing the board and in determining the type of relationship the NEDs were to have with executive directors.

Structuring the board for credibility and influence

Earlier in this study it was identified that NEDs saw themselves as a distinct group on the board, separate from their executive colleagues, with NED ability to influence dependent on the development and maintenance of a good

relationship between both groups. NEDs saw their predominant role as one of challenge to the executives, even if in practice they played a more supportive, informal role outside of the board and formal committee structures.

For the Chair a key aspect of their role was how to help create the right environment for NEDs and executives to work productively together. One tactic was to recruit the right NEDs, and Chairs sought to recruit a board with a diverse range of skills and knowledge. This role for the Chair in selecting the right NEDs for the board to improve its combined knowledge is similar to that within the private sector (Roberts, 2002), though the freedom of the PCT Chair in appointments was more restricted within the public sector at this time as they had to abide by the Appointments Commission's processes and principles of public appointments.

An emphasis in Chairs' accounts was that in the recruitment process attention was given to the resources NEDs could bring and, while Chairs sought a range of experience from NEDs on their board, business skills were particularly sought. This was a policy emphasis following the publication of *Creating a Patient-led NHS: Delivering the NHS Improvement plan* (DH, 2005) and the creation of the new PCTs, which were expected to have more of a business focus then before. A priority for the Appointments Commission, who organised the recruitment process, and for Chairs, was to recruit NEDs with relevant business knowledge to help the PCTs develop this focus. Resource dependency theory (Pfeffer and Salancik, 1978) suggests a key board function is leveraging influence and resources and, in this study, Chairs recruited NEDs to fulfil specific lacks of knowledge and experience within the board to help it respond to a changing policy environment.

Chairs were keen to establish the credibility of the board in their presentations to me as a researcher, with their accounts containing long descriptions of the backgrounds of the individual NEDs on their boards and their professional status. This credibility was identified from analysis as an important factor in board relationships with other organisations, to be further explored, and also for relationships within the board.

This credibility, derived from expertise and background, was one factor influencing how NEDs might be able to utilise their knowledge to make a contribution within the board, as previously examined. It was a factor that Chairs, in considering the dynamics of the board, gave weight to, as in this example from a South-west England PCT Chair:

> *When you've got a fairly touchy executive team who don't particularly want to be challenged because they think they've very little choice, it helps if the people doing it speak from real strength and experience.* Chair 45, PCT D.

The little choice this Chair refers to is in the context of implementing national policy and the requirements of the SHA. However, while the value of private sector business skills that NEDs brought was widely acknowledged by Chairs, they also recruited NEDs able to bring in a community or local focus.

A local board?

One area of interest for this study was to explore how PCT boards managed the tension between national priorities and meeting local need, if felt to be in conflict. As discussed in Chapter One, the policy emphasis on recruiting local people as NEDs changed from having a strong emphasis when PCTs were created to becoming a desirable element but with a greater emphasis on appropriate skills.

For all Chairs in this study, the recruitment of local people as PCT NEDs received strong support. Their local knowledge was seen as necessary to understand the geographical context, as well as the expectations and experiences of local people using health services. This was an important source of information that might support or challenge reports provided by executive directors who did not necessarily know the area well. The local knowledge assisted in the monitoring role of the board but also helped in its strategic role, such as advising where services might best be provided. Specific community knowledge was also a resource for the organisation, such as links to community groups or advice in communications with stakeholders.

While knowledge of the local area and of services was considered important in enabling the board to ensure the services it provided or commissioned were locally appropriate, analysis of the interviews with Chairs showed that having local NEDs on the board was seen as conferring two additional advantages. The first was the sense of ownership it gave the board and having a stake in the success of the organisation, such as in improving health and access to high-quality healthcare. The second aspect was the broader credibility it gave the board within the local community, as this Chair from North-east England explained:

> *So being able to say to a local councillor or an MP, well I live in the area, it's as much of an issue for me as it is for you. And being able to stand up and be counted as a member of the public.* Chair 32, PCT O.

For large PCTs, formed from the merging of smaller PCTs in the 2006/07 reconfiguration, the locality issue had increased importance. The merging of PCTs was a contentious policy issue, with the number of PCTs halving from 301 to 152. In many areas this meant a move from a small, local PCT to one covering a wide geographical area and serving populations of more than one million people. Chairs had to have an eye not only to the skills and knowledge required on the PCT board but also to appoint NEDs who could contribute local knowledge and maintain local relationships as the PCT sought to establish credibility as a larger organisation but without a loss of local focus. This Chair in South-west England, appointed in 2006 to lead a PCT formed from four smaller ones, explained:

> *In bringing together four different cultures I think it was, it was essential to have some local knowledge… actually that's really quite important because, when you're dealing with both, in our case, the county council and five district councils, you, you really, you really do benefit from local knowledge and knowledge of the local councillors if you've got... you can hit the ground running that way.* Chair 50, PCT A.

There was also the political aspect. Chairs needed to establish a board that had credibility with stakeholders, such as the local council and MPs, so recruited NEDs not only with the right skill set but also were an observably diverse board

that provided representation from different areas served by the PCT. The local knowledge and legitimacy NEDs brought confirms one of the benefits of external directors proposed by Pfeffer and Salancik (1978), in a resource-dependency theoretical perspective, and confirmed in a review of empirical evidence by Hillman *et al*. (2009) in the private sector. Within the NHS this role of the Chair in creating and maintaining a board that has credibility – and legitimacy – in the eyes of external stakeholders has received little research attention, although it has been a topic of interest in broader public governance studies (Hinna *et al.,* 2010).

The issue of locality came to the fore again when PCTs merged in 2011, prior to their abolition. PCT Chairs who became Chairs of clustered PCTs looked for the cluster board to have credibility with stakeholders in terms of drawing NEDs from all of the member PCTs, as well as having a range of expertise. These NEDs were seen as playing an important role in maintaining links with local communities during the period of transition.

For those London PCTs that served deprived areas, a lack of local people with appropriate skills caused the Chairs to recruit from outside of the PCT area, as this London Chair explained:

> *I put less emphasis on people having to live in their area and much more on the real professionalism which they had to bring to this job.* Chair 7, PCT L4.

The PCTs in London were generally smaller than elsewhere in the country and local credibility less of an issue. Outside of London there was a greater emphasis by Chairs on recruiting a board that would have credibility with local stakeholders and NEDs able to engage with key organisations and people. This awareness of place and relationships reflects an understanding of governance more aligned to the open-systems model of governance of Newman's (2001) model and the interdependence of the organisation with others as part of a network, an aspect of public governance (Osborne, 2006), rather than the organisational focus of NPM.

Creating and shaping the governance role of NEDs

Previous chapters discussed the range of activities undertaken by NEDs. While many NEDs identified a key role as a conformance-oriented one concerned with monitoring and ensuring the compliance of executives (Tricker, 2015), in practice NEDs were involved in a range of activities that were more performance-oriented, working collaboratively with executive colleagues on strategy development, and becoming more involved operationally outside of the formal board meetings and committees. Influences on the extent of their involvement included their professional background, motivation in becoming a NED and time available. Another influencing factor was how the Chair viewed the role of the NED and limited or encouraged greater involvement.

Within the private sector the Chair has been found to have an important role in creating the environment that maximises the potential for NEDs to have influence (Pettigrew and McNulty, 1995). Within this study, the data also supports the importance of this role for the Chair, although in these self-reports there was little evidence of the types of powerful Chairs who deliberately created structures that concentrated power in the hands of the Chair and CEO (Pettigrew and McNulty, 1995, p. 857). Rather these PCT Chairs appeared to encourage NED involvement and to create the conditions that would allow for NED contribution.

Earlier, the range of meetings outside of the board was identified as providing opportunities for NEDs to gain additional information and to contribute resources. Approaches varied as to how far Chairs encouraged or discouraged their NEDs to get involved within the organisation. The majority (76%) were keen to have NEDs who were very involved within the organisation, contributing skills and knowledge and working closely with executive colleagues, while others wanted NEDs to keep a distance from the organisation, fulfilling a more external scrutiny function.

Apart from subcommittees, several Chairs assigned NEDs to particular areas of interest within the PCT. These assigned areas of interests were seen as

opportunities for NEDs to get to know an area in greater depth but also to input from their own knowledge such as of finance, child protection or public health. This Chair, from a Central England PCT explained his approach:

> *So the advantage of this is to pick an area which the person is already pretty familiar with, and have some expertise to offer, and I must admit I've found the executive team really delighted to have someone who knows quite a bit about the subject and is prepared to spend some time with them.* Chair 26, PCT N.

Influences on how Chairs saw the NED role identified in this study were the organisational history and context as well as their own personal views. One PCT had been rated poorly by the Healthcare Commission in 2008 and the approach of the new Chair to improving the PCT's poor performance was to recruit NEDs who could provide the resources lacking with the PCT and to work in a close, collaborative role with executive directors, sharing expertise. Formal partnering arrangements between an executive director and a NED were put in place, with some shared objectives. They were expected to meet up regularly and for the executive director to give feedback on the NED's performance and vice versa.

This involvement in the organisation to the point of sharing objectives with executive colleagues and being appraised by them was the exception. However, as already highlighted, some NEDs were specifically recruited to provide skills and knowledge lacking within the organisation. Chairs maximised the potential of these complementary relationships through encouraging informal contacts between NEDs and executive colleagues, a similar finding to Roberts' (2002) study of the Chair role in major UK companies.

Authors such as Ezzamel and Watson (1997) and, within the NHS, Ashburner (2003), have suggested that this greater involvement of NEDs in the organisation, outside of formal board meetings and committees can limit their objectivity and scrutiny role. While these concerns were not identified in the accounts of any of the NEDs interviewed, this was an active concern for some Chairs (24%). Too close a relationship with executive directors was felt to

potentially compromise the ability of the NED to remain objective or take action if concerns arose. In response to a question as to why she did not encourage NEDs to have particular areas of interest or to meet up with directors outside of formal committee roles, this Chair of a PCT in the South-west of England explained:

> *I think a non-exec can go native if that occurs. They can either become the representative or the personal advocate and the responsibility of a non-executive is across the whole of the organisation, they are a corporate person… I expect them all to be familiar with everything that they will experience at the board meeting and, well it's important for me, I expect them to be fully briefed and able to participate and critique right across all areas.* Chair 29, PCT B.

The notion of '*going native'*, referring to the non-executive taking more of an insider view rather than an independent one is a phrase that arose several times from Chairs' accounts. As seen in previous chapters, the greater involvement of NEDs in roles that overlapped with management did not appear for them to be in conflict with their monitoring role. No-one identified themselves as having '*gone native*' and, as discussed earlier, NEDs justified greater operational involvement by the needs of the particular context.

Between the two extremes – of NEDs having little or no involvement with executives outside of formal settings and the example of NEDs and executive colleagues working closely on particular areas with shared objectives – were the majority of PCTs. Here the practice was one where Chairs encouraged NEDs to share from expertise and participate in performance-oriented roles, but also to maintain their compliance-oriented ones and to be able to manage any tensions these might present. This meant keeping an appropriate distance between non-executive and executive, as a Chair from a Central England PCT explained:

> *The point about being a good non-executive chairman and non-executive director is that you must keep a distance between yourselves and the executives. I don't mean a stand-off, but you do have to keep a yard between yourselves because if you don't keep that yard then you cannot*

be objective and rational in the way you then evaluate what the executives are doing. So you must always keep that yard between you, and if you do that then you have a very professional relationship between the two, the two organisations. Chair 39, PCT K.

As earlier identified, the majority of NEDs saw themselves as a separate group on the board, distinct from the executives, rather than as a unitary board. In the example above the Chair absentmindedly slips into calling them two organisations. This tension for NEDs in needing to both collaborate with executives but also to keep a distance recalls the requirements of Roberts *et al.* for a NED able to be both independent, but involved and engaged but not executive (2005, p.S21). The findings of this study show the PCT Chair to have had an important role in helping to establish and maintain those norms of behaviour.

Developing the board: the relationship between NEDs and executive

The distinction made between the NEDs and the executives as two separate groups was influenced by the Chair, with some taking a particular lead in developing the NEDs as a separate social group within the board. In some areas this extended to social activities with NEDs, such as meeting at the house of the Chair for dinner. In all bar two PCTs in this study, NEDs met regularly as a NED-only group. NEDs valued these sessions as a source of support and enabling the sharing of experience. For Chairs, these sessions enabled concerns to be shared and also had an educational and mentoring role, with the Chair able to guide NED behaviour and establish the norms of conduct expected of the group.

While welcomed by NEDs, a couple of Chairs cautioned that NED-only sessions could be seen as divisive and detrimental to the idea of a unitary board and so were avoided. Stiles and Taylor (2001, p.113), in their studies of NEDs in the private sector, spoke of the unwritten rule that NEDs do not meet separately in case managers think they are conspiring against them, and this view was supported by these two Chairs in this study. However, while there was an

expressed fear of an '*us and them'* division between the NEDs and the executives in this study, the approach of most Chairs to this was to develop a shared understanding of the different roles and build good relationships between both groups. The importance of different aspects of this relationship, such as professional trust and openness between the NEDs and executives, has already been considered when exploring the board dynamics that enabled NEDs to have influence and to contribute to board tasks.

The Chair played an important role in helping develop these relationships and setting the norms of behaviour. So while challenge to the executive was seen as the dominant role for NEDs in board meetings, Chairs helped establish the norms that that challenge should be presented. There were expectations of respect to be demonstrated and for challenge to be supportive and constructive, rather than adversarial, as in this example from a Chair in South-east England:

> *That challenge should be as a critical friend and supporter, but it should nevertheless be confident and clear about ensuring that due process is there, that the right things have been thought about, etc. So, it needs to be friendly, professional, correct, and confident.* Chair 30, PCT K.

This role of the Chair in setting the tone for board meetings and in creating a culture where contributions were encouraged, with an atmosphere of trust and openness, supports findings from the private sector by Roberts (2002) and Kakabadse *et al.* (2006).

In a few PCTs Chairs had instigated board development sessions, particularly where relationships between NEDs and the executive were recognised as having been poor. An important component of this was to develop an understanding of board members' roles. External consultants were sometimes commissioned by Chairs to help develop board performance, including the use of psychometric tests and giving feedback on observations of the board.

Training and development for NEDs

A further way Chairs helped shape the type of role and contribution they expected from their NEDs was how they controlled the types of induction and

training available. In addition to in-house board development, specific training for NEDs was available through the SHA or external organisations, with the Appointments Commission organising induction training. It was clear from accounts that there was no shortage of possible training opportunities for NEDs, and Chairs took an active role in determining the types of training and development felt appropriate for their NEDs.

Chapter Four identified different types of NEDs and while there were a few who saw the role as part of a career pathway, the majority either positioned themselves as bringing professional expertise to improve the functioning of a public organisation or saw their role as representing certain stakeholder interests to better able the PCT to meet local need. These two different approaches to the role were also reflected in how Chairs approached the training and development of NEDs.

One approach was to seek ways to increase NEDs' corporate skills and knowledge, with Chairs organising management training days led by business schools or external consultants. This focus on expertise from the private sector is a feature of NPM, with its emphasis on increasing the efficiency and effectiveness of the public sector organisation. In some SHA areas, training for NEDs was developed in collaboration with the Institute of Directors, referred to by several NEDs and Chairs in those regions. The Institute of Directors modules were not specific to the NHS but Chairs considered that the information about the NHS could be gained elsewhere, as for this Chair from the South-west of England:

> *We utilised the Institute of Directors and did some of their modules, and that was, that was really quite useful… that, that doesn't necessarily focus on the NHS but it's easy enough to get, get one's training from other areas in the NHS, but skills training in terms of... what it is and what it means to be a non-executive director I think is quite important, and I think the... the IoD did a very good course.* Chair 50, PCT A.

In other accounts there was less emphasis on a managerial approach but a greater emphasis on NEDs increasing their knowledge of the local NHS and the wider community. Chairs encouraged NEDs to meet informally with GPs and

other stakeholders, as well as arranging more formal stakeholder meetings, and, in a few cases, undertaking joint training with NEDs in other organisations. This London NED, from a senior banking background, who joined the PCT in 2008 and later became Chair, explained his approach to induction and training:

> *I mean the thing that certainly has helped me is getting out and seeing stuff on the ground and talking to district nurses and talking to consultants and managers in local hospitals and talk, particularly actually, talking to general practitioners because that provides the context and obviously the local authority, social care and where the overlaps are. So I think it's things like that rather than more formal bodies like the Appointments Commission.* Chair 16, PCT L3.

The value given by the Chair to such activities shows an orientation towards a more-networked organisation and an awareness of the board in needing to respond to differing stakeholder interests. This practice, with a much broader focus on the wider health economy rather than solely organisational efficiency, reflect elements of public governance and a recognition of the need for inter-agency collaboration within networks (Osborne, 2006).

Positioning the PCT board

Chapter Two considered Newman's different models of governance (2001). Drawing on accounts from both NEDs and Chairs, some Chairs (24%) appear to have operated largely within the rational goal model, which was the dominant policy influence, influenced by NPM practices. NEDs were seen as predominantly contributing skills and knowledge from business to improve the efficiency of the PCT. Chairs discouraged too much collaboration with executives or the wider NHS, prizing NEDs' independence and role as external scrutineer. The dominant focus of the board was internally towards the organisation, concentrating on performance and output.

Other Chairs appeared to operate more within the open systems model, seen by Newman (2001) as oriented to network forms of interaction. These Chairs

actively engaged with other organisations and stakeholders within the area and encouraged their NEDs to do the same. Rather than power lying in professional and managerial expertise, power is more dispersed and the ability of the PCT to achieve its goals within society seen as dependent on collaboration with others. This is considered further when examining the role of the Chair as a leader across the local health economy.

Newman (2001) describes her model of governance as a dynamic one, with the different quadrants exerting pulls towards different types of behaviour. The dominance of the rational goal model, with its emphasis on maximisation of output, may have been the dominant policy one, as already identified, but some Chairs responded differently towards this pull, with some embracing this and others resisting it. Those Chairs appointed at the creation of PCTs were more likely to orientate their own and board practice towards external collaboration and a network model, while those appointed more recently or who had come from industry were more likely to act within the rational goal model. However, while their year of appointment and their professional background may be two possible influences, the internal or external context may also have contributed towards an emphasis on internal performance, such as when the organisation was in financial difficulties, or externally, such as when there were challenges in the wider health economy.

While the rational goal model of governance (Newman, 2001) and the meeting of performance targets might have been a dominant concern, some Chairs deliberately framed board discussions differently, as for this Chair appointed in 2006 to a PCT in the North-west of England:

> *When I walk in the room I'm as much a public representative as I am a chair of the meeting. So I try and steer things round to... does that provide a benefit to the public experience?* Chair 52, PCT S2.

A few Chairs emphasised the importance of ensuring that finance and performance issues did not dominate board discussions. Instead they saw their role as ensuring the quality of patient care was kept at the forefront of the

board's mind. However, this theme was less dominant than the importance of meeting performance targets. While PCTs operated within a similar policy context and experienced similar policy tensions, the Chairs played a key role in how the board responded to those tensions and what it prioritised within its discussions.

The contribution of PCT Chairs

Chairs saw the development of what they saw as an effective board as one key contribution. In addition to their contribution to developing the board's performance, Chairs also contributed specific knowledge of governance, often gained from previous NED or Chair roles, or other expertise. All the Chairs brought business knowledge and skills – a prerequisite for appointment – which was also considered an important contribution, as for this Chair in a South-east PCT:

> *So I think what I've been able to do is bring some team building skills together to try and mould the board into a reasonably well functioning part of the organisation. I think that's one thing, I think the second thing I brought is my… HR expertise because there have been times when I've felt the NHS has fantastic policies but it's just awful at applying them and there's a lot of bullying and those sorts of things which goes on and I've tried quite hard… subtly without encroaching on executive roles to try and change that culture.* Chair 23, PCT H.

The role of the Chair in shaping the workplace culture of the organisation, particularly around bullying and whistleblowing, was not a strong theme in accounts, though was mentioned by a few. It was a policy aspect that received greater prominence towards the end of the lifetime of PCTs (National Leadership Council, 2010), and following concerns over standards of care, rather than in earlier guidance (Appointments Commission and Dr Foster Intelligence, 2006b). Softer skills that Chairs considered they contributed were in people management and, particularly, skills in building relationships. Another contribution mentioned by many Chairs was with regard to another key role for the Chair – managing the performance of the CEO.

The Chair and Chief Executive Officer (CEO) relationship

Although the relationship between the Chair and CEO was not a particular focus of this study, nevertheless it was an area that several Chairs referred to when discussing their role and contribution. Chairs were responsible for the performance management of the CEO and, while acknowledging the importance of supporting their CEO, Chairs were prepared to tackle underperformance and, if necessary, organise their departure from the PCT. In three cases, Chairs considered this a key contribution they had made, as a Chair from the North-east of England explained:

> *I brought in some clear focus, some questioning around why things were done this way and not that way. And led what was a very difficult process, that ultimately ended up with the Chief Executive going, and it was being that independent voice with no attachments or allegiances, being prepared to say, you know, talk about the elephant in the room.* Chair 32, PCT O.

When asked what *'the elephant in the room'* was, the Chair referred to the lack of strategy and focus within the organisation. Those interviewed were reluctant to go into much detail regarding the particular circumstances that led to the departure of their CEOs. Recognising the sensitive nature of this and the need to maintain confidentiality, this was not pressed further.

Chairs preferred to talk of the positive relationship they had with their CEOs, with a role for the Chair identified from analysis as mentoring and helping to develop the CEO. The relationship between the NEDs and executives, with expected norms of behaviour, such as mutual respect, has already been examined. These norms extended to the relationship between the CEO and Chair as well, with the need to model a good relationship, as this London Chair explained:

> *I think the Chair/Executive (relationship) is really important actually and building that relationship so we're both illustrating by the way we act, in*

> *the way we interact and what the priorities are for us. What our expectation is in terms of values of the organisation. So you know, thinking around openness and transparency and, you know, sort of, patient centeredness. Those sort of, they have to be demonstrated by the way in which the leadership works.* Chair 1, PCT L2.

The importance of the Chair/CEO relationship for the effective working of the board supports similar findings from the private sector (Roberts, 2002; Kakabadse *et al.,* 2006).

Section summary

This section considered the role of the Chair as leader of the board. In this role Chairs helped create the structures and conditions for board performance that enabled NEDs to contribute to governance. Chairs sought to create and develop a board that had credibility with executives and also external stakeholders, with credibility gained from NEDs' professional experience or local background. Once recruited, the 'right' relationship between the executive and NEDs then had to be developed so that NED contributions were welcome, rather than resisted. This included developing an appreciation of the different roles, along with establishing the norms of board behaviour, so that a positive dynamic of openness and trust could develop.

The Chair played a key role in establishing the parameters of the NED role both within the organisation and externally. For some Chairs the role of the NED was seen predominantly as one that brought skills and knowledge to improve the efficiency of the PCT, with an emphasis on their independence and role as external scrutineer. These Chairs discouraged too much collaboration with executives within the board. Other Chairs actively encouraged close collaboration between NEDs and executives as well as between NEDs and external stakeholders.

The Chair's role within the organisation of leading and helping develop the board and the relationship with the CEO appear similar to their private sector counterparts, though shaped by the public sector context. This influence of being a public sector organisation meant a role for the Chair in helping guide

how the organisation was going to respond to different governance policy shifts, such as the governance pulls identified by Newman (2001) towards a rational goal model or a more decentralised one. Some Chairs steered their boards and own practice towards a more locally-oriented, networked model, rather than a more exclusive, internal organisational focus. The differences in the approach of PCT Chairs with regard to their relationships within the wider health economy are explored further in the next section.

7.2 Leading the local health economy

In addition to their leadership of the board, Chairs of PCTs were also expected to play a leadership role within the local health economy. This was set out in the competencies tested at interview after the 2006 restructuring of PCTs (Alban-Metcalfe *et al.,* 2010).

This local leadership role was one theme identified from respondents' descriptions of their role and contribution, but the emphasis on networking and engaging with the wider community varied across reports. Those Chairs (81%) who saw engaging with other stakeholders in the area as a significant part of their role were more likely to have been appointed Chairs of PCTs at their inception, shortly after or had previously been NEDs in the NHS at that time, later becoming PCT Chairs. Their understanding of governance as networks and the need to work across boundaries to achieve their objectives reflects some of the tenets of public governance and its emphasis on interorganisational relationships (Osborne, 2006). These elements of collaboration were more dominant in the early 2000s, which Newman (2001) sees as the period when the Labour Government was emphasising the open system and self-governance models of governance. As discussed earlier, this understanding of governance by Chairs influenced not only their own actions, but also those of the NEDs on their boards.

For four Chairs appointed more recently, and who had not previously been NEDs in the NHS, this local leadership role had less emphasis. This was a time

when the policy emphasis was an organisational focus on economic rationalism (Ham, 2009) and may have influenced their selection and role. However, for many Chairs, collaboration with other stakeholders was seen as fundamental to enabling the PCT to meet its objectives. This Chair, originally appointed as a NED to a pilot PCT in Central England in 2000, described her role:

> *And to work and to develop relationships with partners to keep the, to keep the engagement with those key stakeholders, so you are creating the environment in which you can do business.* Chair 38, PCT M.

Another Chair, originally a NED on a SHA before being appointed Chair of a PCT in the North-east of England, considered community engagement as a major aspect of her role:

> *The stuff that I've probably done the most of while I've been chair has been around public engagement, working with key stakeholders, bringing them into the loop, engaging with them, and then governance. Chair 32, PCT O.*

These wider community roles are in contrast to the more organisationally-focused roles of those Chairs appointed more recently. These community-focused Chairs engaged in a range of activities, from informally meeting up with key stakeholders such as the local Bishop or community leaders, to a range of more formal activities. Their wider focus extended to their expectations of their NEDs as well.

Four of the Chairs in this study highlighted the informal meetings they organised for NEDs from a number of NHS organisations to come together, with the expectation of building relationships across organisations. These were seen as complementary to the work of the executive, as in this example from a Chair in the South-east of England:

> *The non-execs meet informally with the non-execs of the providers, in other words, for example, take the big hospital now the (…) Trust, there, there are lots of issues between the, the commissioners and the providers. The non-execs help to carry that through by socialising with*

> *the non-execs, the providers, and came back with some ideas. We then got together on a board-to-board basis.* Chair 13, PCT G.

Earlier in this study the ability of NEDs to draw on relationships with key stakeholders in the community, and so influence board decisions, was considered a source of power within the boardroom. Some Chairs in this study were able to exercise power and influence across the broader arena of the local health economy. While they were able to draw on their structural power, the other elements of Pettigrew and McNulty's (1995) framework were important too, particularly the will needed to act and the skill to be able to utilise that power. In Chapter Four a public service identity and commitment to public service values was seen as providing a motivation for the NED role. For the Chair, a public service identity, along with a greater orientation to a network governance model that saw interorganisational collaboration as necessary to achieve organisational goals, appears to be the motivation to proactively seek this wider engagement.

The interpersonal skills of the Chair were important in building the right relationships with other organisations, and complementary to the work of the executive, as in this example from a Chair of a PCT in the North-west:

> *I believe one of the successes I had was to get the two hospitals which were providers to (a) Primary Care Trust to work together collaboratively to see how they could share some services across a bigger region which was (b) hospital and (c) hospital and subsequently I did that at a non-executive level with the chairs of those organisations and the chief executive was supporting me by similar conversations then with the chief executives, and they eventually came together and signed a joint venture agreement.* Chair 40, PCT 40.

In some PCTs there appeared to be no broader role for the NEDs external to the PCT, but where a Chair embraced this wider leadership role and a way of working that saw the PCT as part of a network, then NEDs also had a broader role, rather than a narrower organisational one. This external networking role is

an aspect that has not previously received any prominence in the existing literature on the NHS NED and Chair role.

This broader leadership role of PCT Chairs across the health economy is different to what might be expected of Chairs in the private sector. Another crucial difference is the differing accountability relationships within which PCTs were situated, required to look up to the authorising agent, the Department of Health, via the SHA as well as down to the operating level. The Chair of the PCT played a key role in this interface, acting as sometime mediator between the SHA and the PCT.

The mediating role of PCT Chairs

As discussed in previous chapters, NEDs considered the SHA managers as hindering the efforts of the PCT to be a locally responsive organisation, due to its performance management role across the region. This was also a common view for Chairs, as for this Chair in South-west England, in response to being asked how his experience in a PCT compared to his experience of serving on other boards:

> *I think the PCT has to deal more with interference from on high, and a top-down approach, so one level one's meant to be autonomous, another level there are different mechanisms for the department or the SHA to seek to control the activities locally, and sometimes the board can be marginalised* Chair 48, PCT C.

The effect of this control from the SHA was felt by a third of Chairs to be disempowering and for a couple to undermine their leadership role, which led to dissatisfaction and frustration. Experience varied, however, with other Chairs accepting the performance management role of the SHA and still feeling able to exercise local autonomy.

This study found that, while all PCTs were subject to the same national policy directives, the extent to which the board, led by the Chair, was able to exercise power and still forge their own strategy and influence local implementation was

dependent on a number of factors. One was the approach of the SHA, with some perceived as more 'hands off', enabling greater PCT autonomy. Two Chairs in the South-west of England, both with many years of experience, disagreed that there was limited autonomy for boards, providing the PCTs were performing well:

> *You've heard we are a high-performing PCT, if you perform and get ahead of the game, you're left alone, which we have been, to get on with the more interesting things and the innovation, and... yes, OK there are frustrations along the way, like... getting capital and things like that, but, by and large we set our strategy, we've delivered our strategy and we've had very little interference from the... strategic health authority.* Chair 50, PCT A.

> *My personal experience with the SHA has been that they have a very strong hand if you're an underperformer, yeah? And I think that's right. But my experience, we're lucky because we've got a high-performing PCT and we've got a high performing cluster, we get left to our own devices. And the rules are clear as far as I can see, right? Deliver the goods, we'll leave you alone, yeah?* Chair 29, PCT B.

Other SHAs appeared more controlling, which might have arisen from the particular organisational context. The PCT might be high performing but still come under pressure to help out neighbouring Trusts that were poorly performing, so reducing its ability to set and meet local priorities, as discussed previously.

While acknowledging their limited autonomy, just over half of Chairs (57%) in this study still felt their PCTs had been able to meet local needs, as this Chair from the North-east of England described:

> *I think that we're always able to... to get the best for the patients and public that we serve in our area, regardless, you know, despite the SHA and the Department of Health. Chair 47, PCT Q.*

These Chairs who appeared most able to achieve locally-appropriate goals and for the PCT to have some independence in this had all been in post since PCTs were created. These Chairs acted as arbitrators between central demands and what they perceived as being in the best interests of local communities, able to exercise some authority and influence with the SHA. It called for particular skills in negotiation and the ability to build key relationships, such as with the SHA Chair. PCT Chairs described a role that included the ability to '*work within wheels'* as they negotiated between central demands and local needs.

When considering power and the dynamic relationship between context, structures and personal actions, then it appears that where Chairs had been in post a long time, their actions in achieving greater autonomy of their board set the scene for further successful negotiations between the SHA and PCT. The confidence gained, and power derived from key relationships, gave these Chairs greater power within the region than more recently appointed PCT Chairs. They also appear to have occupied roles as senior statesmen, able to advise and influence policy at a regional level.

Those PCT Chairs who were appointed since 2006, and had had no previous experience as a Chair elsewhere within the NHS, appeared more accepting of the centralised system within which the PCTs operated. The mediating role was not a theme in their accounts in the same way that it was for more longstanding Chairs.

An overarching area of interest for this study was how the board was able to mediate between national priorities and local need, where these were perceived to be in conflict. However, as first identified when considering the role of NEDs, the emphasis differed on whose interests were to receive priority or be defended. For a few Chairs, local interests had a priority as for this PCT Chair in the South-west of England:

> *I think we've probably, we've always taken the view that we'll try and work out what we want to do locally that works for our population, with our clinicians and our partners and stakeholders, and then we'll work out how we retrofit it to make sure we, we're in accordance to the government guidelines.* Chair 48, PCT C.

However, for other Chairs, the first priority was their accountability to central government, referring to the need to '*obey the rules'* in implementing national policy, with an acceptance of the role of central government in setting policy and their role in policy implementation. For a London Chair the accountability to central government was clear: '*we're public servants, we'll deliver as we're told'* (Chair 5, PCT L5).

The majority of Chairs, though, described a role that saw them trying to mediate between local and national priorities, to be both a locally-responsive organisation while still meeting central demands. Their success in achieving these dual objectives varied, as has been seen in examples presented in this and previous chapters.

Section summary

Those Chairs who had been appointed at the creation of PCTs saw a significant part of their role as the networking with other stakeholders. These were seen as fundamental to the PCT meeting its objectives and reflect understandings of governance allied to Newman's (2001) open-systems model. By working proactively with other stakeholders in the health community, Chairs considered they had been able to achieve better partnership working and results for patients. Other Chairs appeared more oriented towards a rational goal-model of governance, which focused more explicitly on the organisation rather than interorganisational relationships.

An aspect of the Chair role, unique to the public sector, emerged as acting as an arbitrator between central demands and what are perceived as being in the best interests of the local community. While this emerged as a role for NEDs, the Chair played a key role in the interface with the SHA. The power the Chair was able to exercise varied, with some SHAs seen as more controlling then others. Chairs, however, also varied in how they saw their role, with some identifying their role as implementing national policy, first and foremost. Others showed a greater orientation to a more local organisation where greater priority was given to local needs. Once the abolition of PCTs was announced, the mediating role between SHA and PCT seemed to lessen and there was more

overt resistance by Chairs to some national directives, which is discussed in the next section.

7.3 Impact of change: the clustering of PCTs and transfer of functions

For Chairs, the clustering of the PCTs required to reduce management costs in the lead up to the abolition of PCTs, was not perceived as being in the best interests of their community as it resulted in a much larger organisation serving a greater geographical area. This view may have been influenced by personal circumstances, however, as many Chairs became vice-chairs within the new arrangements.

A particular cause for resentment was that the policy to cluster was imposed on PCTs, with Chairs having limited power to alter its implementation. The impact of the impending PCT abolition was to affect the role the PCT Chair had in the broader system. The mediating role described in the previous section appeared to have vanished, leaving PCT Chairs unable to have the influence they once had within the wider system, as this Chair in a Central England PCT explained:

> *You lost that voice in the system because it used to be… we were very useful touchstone or lightening conductors to test out how policy is working on the ground. And it used to be that actually that through the system you could feed that through to SHA chair and they would meet regularly and nationally and could tell, conform and shape what's happening.* Chair 38, PCT M.

This loss of an influencing role led to a more direct use of power by this PCT Chair and one other Chair to obtain policy concessions they saw as essential for patient interests to be protected. In these two PCTs, in different parts of England, the directive for PCTs to cluster was seen as particularly problematic as the PCT had developed partnership-working arrangements with the local authority that were felt to be in jeopardy if the PCT had to share a management

team and board across a wider geographical location. The directive to cluster PCT management and move towards greater centralisation gives an example of the tensions different policy requirements can place on governance (Newman, 2001). The Chairs in both areas demonstrated a priority for the partnership model between the NHS and the local authority rather than the imposed model of joint management across PCTs.

In these two PCTs the NEDs and Chairs resisted the policy. National media coverage was obtained to draw attention to the threat to integrated working and this Chair, in the South-west of England, explained the further actions he and his NEDs took to block the imposed timetable:

> *Submissions were made by (…) Council, the CCG and LINk (Local Involvement Network) to the SHA that any premature board clustering would be contrary to the best interests of patients and residents and CCG development and (in the Council's case) the specific contractually binding terms of the extensive Health & Wellbeing Partnership…*
>
> *My NEDs refused (without my prompting) to apply for cluster board positions in the timescale required as any application would have required them to stand down as NEDs. We all believed the original timescale of… was right for us and didn't want DH/SHA top-down instructions ignoring local agreements and wishes.* Chair 48, PCT C.

The Chair and CEO of this PCT received pressure from the SHA but the extended timescale was eventually agreed. The insistence of the Chair, NEDs and other stakeholders that the integrated way of working was recognised led to additional powers of partnership being granted to the emerging CCG and appropriate protection for the existing partnership arrangements. The NEDs were regarded by the Chair to have played a major role in refusing to follow the centrally-set timetable regarding clustering, whereas the executive team was less keen to take a confrontational stance. The professional independence of the NEDs was a source of power here, which enabled them to challenge the SHA.

As already discussed with reference to Pettigrew and McNulty's (1995) analytical framework, the exercise of power is a dynamic one. Actions in the past influence the context for the exercise of power in the future. The Chair of the PCT in the West of England had previously refused to merge his PCT with another one in the 2006 restructuring. He '*had form'*, as he put it, which seems to have set the scene for this current interaction with the SHA and to have given him and the PCT board greater power to resist the imposed timetable for clustering and significantly change aspects of its implementation in a way many PCTs appeared unable to.

These two exceptions apart, the dominant theme that emerged was that the directive to cluster PCTs was a very centrally-driven process the majority of PCT Chairs had little ability to influence, with any locally-determined cluster governance arrangements forced quickly to adhere to a national model. The process of change was also felt by some to force them to act in a way that conflicted with their values.

The role of the PCT Chair during transition

With the new Coalition Government in place, respondents felt PCTs were perceived negatively and associated with NHS problems of the past. The NHS White Paper (DH, 2010a) referred to the reduction in levels of management and bureaucracy to be achieved by the abolition of PCTs and SHAs. The PCT Cluster Chair was required to take on a rationalising role to meet Government targets of managerial reductions. Many PCT NEDs and Chairs had to relinquish their positions and this top-down process, which put them in a position where they had to '*fall on their sword'* as there were no processes in place to terminate appointments except due to misconduct, caused conflict with the public service values Chairs ascribed to.

Despite the negative rhetoric and the lack of support these Chairs considered they received, the concept of public service appears to have guided their behaviour and role during the period of transition prior to abolition.

The previous chapter identified that in this time of transition a role for the NED that came to the fore was as a defender of the patient interest. For the Chair this was also a role but was accompanied by a broader public responsibility of ensuring a public service was run efficiently until the end, when responsibilities were handed over to successor organisations, as in this excerpt from an interview with a Chair in South-east England:

> *So it is to try and transfer knowledge, skill and expertise across to those new organisations so that they can pick up the baton and run with it and make sure there, there is nothing in the… there's no skeletons in the cupboard which they are not aware of.* Chair 23, PCT H.

The desire to leave a '*good legacy'* was a dominant theme from Chairs when considering their current role in the time of transition. This meant ensuring that functions being transferred were in as good a state as possible, with financial plans that were sustainable and ensuring that all corporate knowledge was passed on to the successor organisations. Other important aspects of the Chair role in the transitional phase were to ensure that high standards of governance were maintained, including principles of accountability and transparency such as with the transfer of staff to new positions.

So in this time of transition and the abolition of a large number of public organisations, a role that comes to the fore for PCT Chairs is as holders of public value. These values include the public sector's contribution to society and the relationship between public administration and the citizen (Jorgensen and Bozeman, 2007). This public service identity and guiding values and expectations of behaviour provide one distinct difference between the public sector Chair role and what might be expected of the private sector one. From many of the interviews it was apparent that this time of transition prior to PCT abolition was one not felt to be personally rewarding to Chairs; rather, it caused considerable tension. However, these public service values appear to provide a motivation to continue, with a desire to protect the public interest and ensure a safe transition to new structures.

Section summary

The role for PCT Chairs changed considerably once the abolition of PCTs was announced, requiring many PCTs to cluster their management structures and boards, and to prepare for abolition by transferring functions to new organisations. The requirement to cluster PCT boards within a set timetable was resisted in some places, with priority given to local partnerships. Confirming an earlier finding of this study, the impending abolition of SHAs and PCTs appears to have empowered some NEDs and Chairs to take more-overt actions to challenge the power of the SHA and to insist on different arrangements.

A role for Chairs in maintaining the public values of the organisation in this time of transition came to the fore. This included outcomes such as ensuring the smooth transition of functions to new organisations in a way that did not have a negative impact on patients or the public.

Chapter conclusions

This chapter has identified particular roles for the Chair, in addition to those of the NED on a PCT board. Although they are NEDs too, in sum, they have an internal role as leader of the board and an external role as a leader within the local health economy as well.

Within the organisation the Chair had a key role in shaping the kind of roles their NEDs were to play, and in creating the structures and context to enable them to have influence. By guiding and directing the involvement of NEDs outside of the board and also the types of training provided, Chairs played an influential role in how the NED role was played out within the PCT.

For one set of Chairs the role of the NED was more clearly conformance-oriented, providing external scrutiny and prizing independence (Tricker, 2015). NEDs are seen as the external experts, able to both contribute from their

professional expertise, and a key concern for Chairs was to preserve the independence of the NED. The dominant focus appeared to reflect an agency relationship between NEDs and directors, with Chairs orientating their NEDs more towards the control aspect of the role (Chambers *et al*., 2013).

For other Chairs, greater emphasis was given to NEDs working collaboratively with executives, but always with an awareness of the distinction between both roles. Chairs encouraged a range of activities outside of the boardroom, including informal or more formal partnering between an executive and a non-executive. This reflects more of a stewardship relation between NED and executive (Davis *et al.*, 1997).

Previous chapters considered how the NEDs identified themselves as a separate group within the board. Chairs encouraged this, with the majority arranging separate meetings of the NEDs, but were also keen not to establish an 'us and them' division between executives and NEDs. To enable these two groups to work effectively together, Chairs implemented a number of strategies. The first was in recruiting NEDs with appropriate expertise and credibility in the eyes of the executives. The second was in developing the board so that roles were understood and relationships between the groups developed. A third role for the Chair was in setting the values for the organisation and the norms of conduct within board interactions. These strategies set a context within which the NED could exercise power, while acknowledging the personal motivation and skills required by the individual NED to successfully exercise that power.

In many of these organisational aspects the role of the Chair appeared similar to that within the private sector (Roberts, 2002; Kakabadse *et al.,* 2001, 2006). However, an additional aspect to the role was how the Chair guided the board in its response to different policy initiatives and oriented itself towards different models of governance, such as the rational goal model or open-systems model (Newman, 2001).

Those Chairs who had been appointed at the creation of PCTs saw a significant part of their role as networking with other stakeholders. This was seen as

fundamental to the PCT meeting its objectives and reflects understandings of governance allied to Newman's (2001) open-systems model. These findings give support to Osborne's (2006) views of the limitations of NPM within the public sector, with its organisational focus, and the need instead for a model of public governance that stresses interorganisational relationships and the governance of processes (p. 384). A few Chairs, who had been appointed more recently, appeared more oriented towards the rational goal model, with a greater intraorganisational focus rather than seeing the PCT as part of a network.

The skills required of the PCT Chair included the ability to mediate between the SHA and the PCT, to enable the latter to achieve some local autonomy while retaining the approval of the former. Sources of power included relationships with key stakeholders, but a greater emphasis was given to the skills and ability of the Chair in being able to negotiate. Confirming that the previous exercise of power within a relationship influences subsequent encounters (Pettigrew and McNulty, 1995; Stiles and Taylor, 2001), Chairs who had previously been able to exercise power within the relationship with the SHA and achieve local autonomy in some policy areas, went on to have greater influence in the relationship with the SHA when compared to other Chairs.

The Chair therefore had an important role in how the board was going to respond to tensions between national and local priorities, a key question for this study. Their response to policy directives shaped whether the board not only gave a greater priority to local priorities and partnership working but also was able to exercise the autonomy to do so.

This chapter concluded by exploring how aspects of the external context influenced the role. In a time of transition, a role for the Chair as a protector of public values and the public interest came to the fore. This included the protection of patient interests, already identified as a role for NEDs, but also a broader role in protecting public interests through ensuring the safe and efficient running of the organisation until its abolition. The salience for Chairs of a public service identity and the values associated with that role is one of the findings

from this chapter. This not only provided a motivation for them to remain in post until the final closure of PCTs but also caused some conflict when these values were felt to be at odds with the process of rationalisation required by the Government when PCTs were forced to cluster.

The next chapter is the final one of this thesis and discusses the findings of this study and implications for future practice.

Chapter Eight: Conclusions

This chapter draws together the findings on the governance role of NEDs and Chairs and their contribution to the governance of PCTs. The final section examines implications for the role of the NHS NED today.

This research into practice was identified as an area of interest by the researcher, who, as a NED herself, was aware of the complexity of the non-executive role within PCTs, which were NHS organisations set up to provide and commission care for local communities. This model of corporate governance of unitary boards with non-executive directors and Chairs is imported from the private sector but can cause tensions in the NHS. A source of some of these is when financial and performance accountability to Parliament conflicts with expectations of accountability to patients and local communities for the provision of their local services.

The catalyst for this research was the launch of the 'democratic accountability project' set up to explore ways that PCTs, as local NHS organisations, could be more accountable to local communities. Tensions in accountability have been highlighted throughout this thesis, and challenge an assumption that a model of corporate governance and accountability from the private sector can easily be incorporated into the public sector.

Existing research, while not directly focused on the NHS NED role, revealed a lack of clarity around the role and raised questions as to NEDs' contribution to governance within the NHS. In contrast to existing studies, this research sought to examine the role through a practitioner focus. The researcher was interested to explore how non-executive directors understood their roles and the contributions to governance they felt able to make. This was achieved by exploring the first-hand experience of 52 NEDs and Chairs serving on 37 different PCT boards across England.

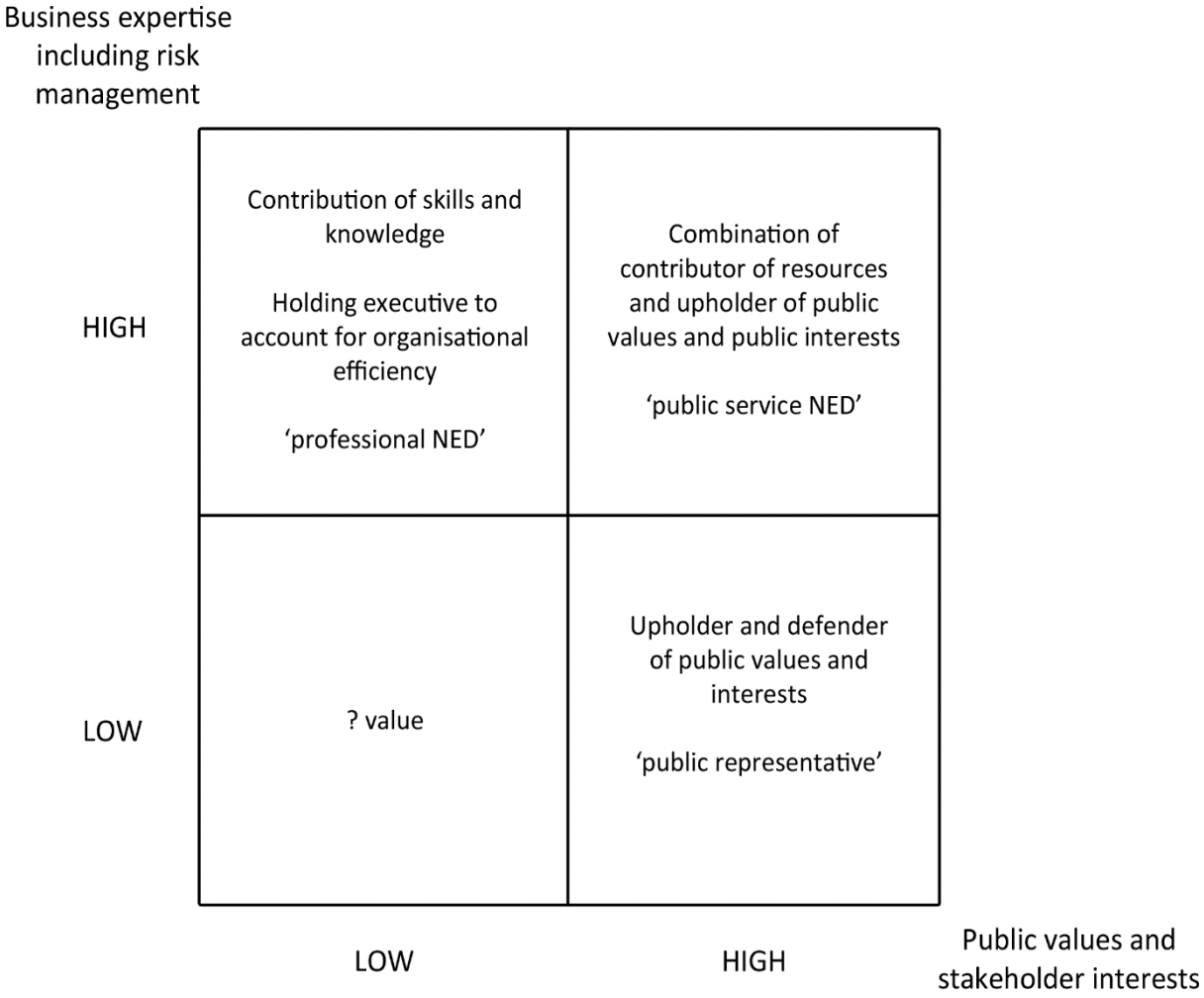
8.1 The role and contribution of the non-executive director

A key contribution of this study is the identification of different groups of NEDs within the PCT board, with differing skill sets but also understandings of accountability.
Factors identified as influencing the NED role include the professional backgrounds, skills and experience that led to NEDs taking on different types of roles within the PCT. However, other influences were also identified, such as the strength of a social identification and whether NEDs saw their accountability to local people and patients or as a broader public accountability.

Reflecting on the NED role within the private sector, Pye and Camm (2003) note the tendency to talk of NEDs as if they are a homogenous group (a practice also found in the NHS) and suggest that rather there are different types of NEDs who fulfil different roles. The findings of this study would support this and I propose that different types of NEDs are able to fulfil different, complementary roles on NHS boards.

Pye and Camm (2003) identify four types of NED contribution, which they map according to the level of involvement in risk management or strategy (see figure 2.3, p.56). I have adapted their model in the light of the findings of this study and this is presented in figure 8.1. The vertical axis represents the extent to which NEDs contributed business expertise, retaining the risk-management element of the original model. The other dimension represents the extent to which NEDs played a role in upholding public value and representing stakeholder interests. The strategic element of Pye and Camm's (2003) model appeared less important within this study, as this was largely determined by central government. However, NEDs did have a strategic role and particularly a gatekeeping one in ensuring the interests they represented were not harmed and that public values were upheld, so this is encompassed in the horizontal axis.

Figure 8.1: Four types of non-executive role contribution in PCTs, adapted from Pye and Camm (2003).



Contained within the four quadrants are different types of NEDs, whose attributes were first identified in Chapter Four and their roles further explored in subsequent chapters. In the top-left quadrant are those NEDs whom I have labelled 'professional NEDs', who brought a high level of expertise to the organisation. As identified earlier, there were a few NEDs who did not appear to have a strong identification with stakeholders but saw the role as a job and more of a career opportunity.

In the bottom right are those NEDs I have labelled 'public representatives'. Chapter One described how the role had moved from having a representative aspect in 2002, when PCTs were first created, to a clear policy instruction that NEDs were not there to act in any representative capacity (DH, 2004).

However, as presented in Chapter Four, many NEDs had a salient identity with stakeholders and saw part of their role as representing those interests. Those NEDs who did not identify themselves as having a private-sector business background but had other areas of expertise had a stronger identification with local communities or patients than those who did.
In this role, NEDs promoted public values in areas such as the relationship between the PCT and local citizens, including equity, dialogue and user orientation (Jorgensen and Bozeman, 2007 p.360-361).

The top-right quadrant represents those NEDs who both contributed business expertise and had a salient stakeholder identity. This group was more likely to see their role as representing the interests of the broader public, rather than local stakeholders, keen to provide public value. I have labelled this group the 'public service NED', as distinct from the 'professional NED' who played a similar role to that found within the private sector.

The bottom-left quadrant of the model is a group of NEDs that did not feature in these self-reports, but would appear to add little value. Chairs perceived that some NEDs from a community background, who had previously served on their boards, lacked the skills and capacity to act. It may be worth stressing that the value the more-representative NEDs in this study felt they were able to bring was precisely because they *did* possess the skills and motivation to use the power sources available to them to act on behalf of those groups with whom they identified.

This finding of the different types of role for the NED is one contribution of this study. While the focus in recruitment and guidance (DH, 2004) moved away from a representative role for the NED and emphasised a role more aligned to one found in the private sector, with an emphasis on the NED's contribution to the efficient running of the organisation, this study found that the representative aspect was still an important one for how NEDs perceived their role.

This is important with regards to democratic accountability, which was the initial question that prompted my study. Most NEDs **did** consider there to be a

representative aspect to their work, but the accountability mechanisms to stakeholders were weak. The dominant accountability was hierarchical, to government. The most influential NEDs were those with financial or commercial skills, others who were more citizen-based found it harder to make a difference.

Performance- and conformance-related roles

The previous section identified different groups of NEDs; the public service NED, the public representative NED and the professional NED. A further interest of this research was to identify how the NED role was enacted on the board, whether this was a conformance-oriented one, internally facing and concerned with present performance or a performance-oriented one, forward facing and outward looking. As discussed in Chapter Four, the conformance-oriented aspect of the role was the dominant one identified. The professional NED and public service NED, with their business backgrounds, were particularly strong in this area with an emphasis on organisational financial performance.

However, NEDs also contributed to roles that were externally focused. As discussed in Chapters Five and Six, NEDs helped connect the board to useful stakeholders, including local councillors, MPs, other NHS organisations and patients. The commissioning role of PCTs meant there were elements of the NED role that did not fit neatly into the division of conformance and performance elements of the role as described by Tricker (2015). As policy and public expectations changed – and in the absence of formal guidance – NEDs adapted their role. When the policy environment changed to become more market oriented and executives lacked specific market experience, then NEDs contributed business knowledge and skills.

This contribution to what might be considered operational roles, such as hands-on involvement in procurement exercises, was a possible cause of tension, between this and the non-executive role of oversight of process. However, this did not appear as a particular issue in accounts, though was a concern for the majority of Chairs, who were keen to ensure the NEDs on their boards

remained *non*-executive. In practice, NEDs felt able to act to protect stakeholder interests in a monitoring role but also to work collaboratively with executives, contributing expertise in a range of informal meetings outside the formal board and committee roles. This ability to hold in tension roles in both collaborating with managers while still holding them to account, without apparent difficulty or conflict, supports findings in the private sector by Stiles and Taylor (2001) and Roberts *et al.* (2005).

An overarching role for NEDs and Chairs was identified as a defender of the public interest, whether perceived as local or national, and adapting their role as they saw the circumstances required. When there was an increased emphasis on the quality of care provided in hospitals, NEDs took on what could also be seen as more operational roles, going into hospitals to inspect wards. They also acted at a more corporate level, building relationships at a board level with other organisations and utilising these relationships to help organisational collaboration, where there was potential or actual conflict that might impact on patient care. This range of roles undertaken outside of the boardroom is a significant contribution of this research, where prior research has usually focussed on the role of the NED in the board and committee room.

The research took place when there had been close political scrutiny of NHS finances, so the finding that the dominant role for the NED was a conformance-oriented one that was internally facing and concerned with present performance – with a particular emphasis on finance – was not surprising. However, while this aspect of governance might appear to be the most straightforward, it was not without its tensions, for example when the organisation was required to provide financial assistance to other part of the health economy. The power dynamics between the PCT board and the SHA, who could demand such actions, have been examined through the first-hand accounts presented here, such as when the PCT allocations were top-sliced (p.190) or PCTs required to contribute to a local hospital in financial deficit.

The contribution of PCT NEDs

This was one of the primary objectives of this study, to consider the contribution of PCT NEDs and Chairs. It found that they contributed in two particular areas – helping the PCT fulfil its role as a local organisation, and increasing the efficiency and effectiveness of the organisation.

As explored in Chapters Five and Six, different groups of NEDs were able to contribute in different ways to the governance of the PCT. The public representative NEDs were able to help the PCT to be responsive to local needs through the contribution of locality-specific knowledge and access to key stakeholders. They also acted as a conscience for PCT boards, reminding colleagues of the needs of patients and local communities if, at times, these appeared secondary to other considerations.

The 'public service' or 'professional' NEDs with particular business skills contributed from their expertise to help improve the efficiency of the PCT by providing scrutiny and challenge to managers, as well as contributing specific financial and commercial knowledge. Those with accountancy backgrounds saw a significant contribution through their position on the audit committee. While a dominant emphasis in accounts was the contribution made to improving the financial position of the PCT, NEDs also contributed to ensuring that services commissioned provided a high quality of care.

As already discussed, an overarching role for the NED was as a defender of patient and public interests when these appeared threatened by national policies that seemed inappropriate for the local context, such as the Darzi centres considered in Chapter Six. By representing the interests of stakeholders and assuming a mode of challenge to executive colleagues, NEDs created accountability by acting as a public voice. This role in creating accountability was suggested for NEDs in the private sector by Roberts *et al*. (2005) and in guidance for NHS NEDs (National Leadership Council, 2010). It would appear that for some PCT NEDs, at least, they did act as the public voice

suggested by the Prime Minister's Strategy Unit (2007) and as envisioned by Williams *et al.* (2007).

The role and contribution of the PCT Chair

The Chairs in this study had a key role within the organisation in helping determine the power and contribution of the NED. This was encouraged by Chairs who put in place conditions for the NED to have influence, such as creating a board that would have credibility with executive directors and external stakeholders. The Chairs also provided a structure and culture where NEDs were encouraged to increase their knowledge of the organisation, by assigning them to a particular area to develop further their knowledge and thereby not only help address the information asymmetry with executive colleagues but also facilitate the contributing of skills and knowledge.

Approaches varied, though, as to whether Chairs encouraged or discouraged meetings outside of formal committee settings between NEDs and executives. For some Chairs their understanding of the NED role was to provide an external perspective that may be compromised were the NED to become too closely involved with operational detail.

The role of the Chair was influential, not only in helping shape the degree of involvement a NED had but also in setting the norms, values and culture of the board and organisation. While this may be similar to the role in the private sector, a particular emphasis of the role in the public sector was the more explicit conceptualisation of public values by some Chairs, such as ensuring the welfare of the patient was at the forefront of discussions.

There has been little research into the role of the NHS Chair, but where this has been considered in studies on NHS governance the focus has been on the Chair's role in managing the board (NHS Confederation, 2005; Endacott *et al.,* 2013). A contribution of this study are its findings around the role of the Chair as a leader in the local health economy, able to create and utilise relationships with

other key stakeholders to enable the PCT to meets its primary aim of improving the health of its population (NHS Appointments Commission, 2003; DH, 2007).

The Chairs of PCTs played a key role in shaping the role and focus of their NEDs, whether this was to be on the internal organisation or to include a broader role that involved a more collaborative engagement with other organisations. Influences on this included the particular context for the PCT, such as particular challenges in the local health economy, and the personal views of the Chair and their responses to different policy 'pulls' towards different models of government (Newman, 2001). For those Chairs appointed when PCTs were created, the external-facing role features strongly in their accounts. One finding of this study was that this went beyond engaging with stakeholders as part of good public relations but due to an understanding of the PCT as part of a networked form of governance, the 'open-systems' quadrant of Newman's model (2001).

This is explored in greater depth in the next section which considers how corporate governance in the public sector differs to that within the private sector.

8.2 Corporate governance in the public sector: the influence of the external governance context

The focus of this research has been on the NED and Chair role in corporate governance, an import from the private sector and which refers to the structures, systems and processes of an organisation, concerned with how the board provides overall accountability, direction and control. However, it has recognised that the corporate governance of the organisation will differ in the public sector, as it will be influenced by different conceptualisations of systems governance (Newman, 2001). This study has shown the external governance environment to be an important influence on the NED and Chair role.

Newman's (2001) model has proved appropriate for this study as it is a dynamic one, able to explore tensions in practice and provides a frame for exploring the sometimes-conflicting pressures on PCT boards noted by Abbott *et al.* (2008) and Storey *et al.* (2010). In this section, further consideration is given to how different Government policies and 'pulls' towards different models of governance influenced the role of the PCT board and its directors in ways quite different to the role enacted in the private sector.

Public sector organisations, such as PCTs, had to act within the spirit and constraints of Government policy, which changed in emphasis over time. The public sector context and Chair's interpretation of the type of governance model required of the PCT – whether hierarchical accountability or acting as part of a network – led to variations in the NED role with regard to other stakeholders. The power of other actors also influenced the extent to which the board could exercise power, impacting the ability of the NED to have influence in how national policies were to be implemented locally, for example.

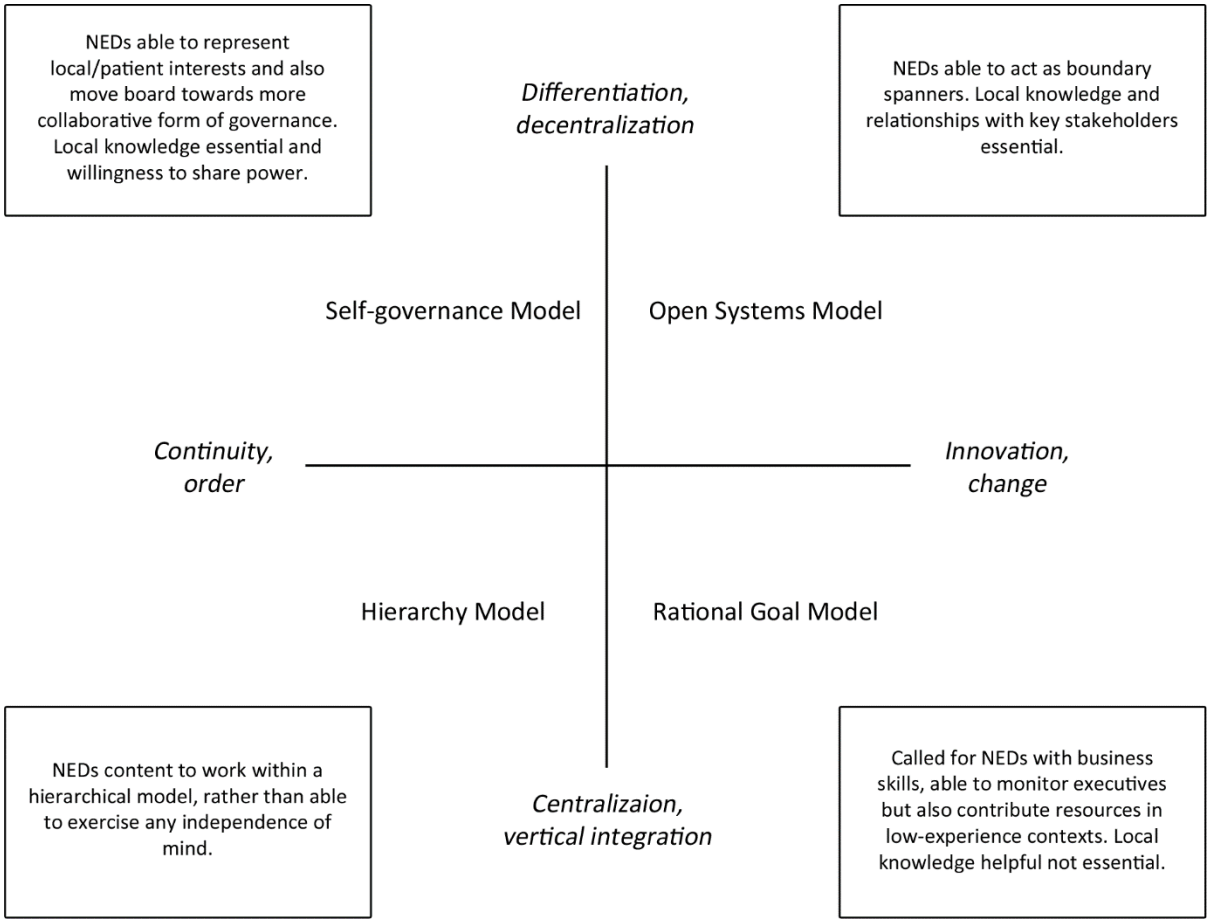
At the creation of PCTs, their model of governance was more decentralised, oriented more towards the open system, based upon flows of power within networks, and self-governance models of governance, based upon citizen or community power (Newman, 2001, p.38). Later emphasis on economic rationalisation and performance measurement saw PCTs pulled towards the rational goal model of governance, based on managerial power, which focused more explicitly on the organisation. This study has found that financial accountability proved to be the strongest one. There were though elements of the open system and self-governance models that remained throughout the Labour Government's time in power, requiring collaboration and new forms of public participation. However, these caused tensions with the dominant rational goal model and its intra-organisational focus and hierarchical accountability.

Newman's (2001) governance model proved useful for this study as it could accommodate both stability and transition. During the period of transition

between the proposed abolition of PCTs and the setting up of new structures, dynamics shifted. Whilst the 'pull' towards the demands of the rational goal model and hierarchical accountability remained, with the key player the SHA soon to be abolished, Chairs in this study instead gave greater attention to local organisations and communities, which have greater importance in the more devolved and diverse models of governance.

Newman (2001) is not concerned with the role of boards of public sector organisations and, indeed, her original work predates the widespread introduction of PCTs. However, the application of her model to my findings on the role and contribution of PCT NEDs and Chairs helps conceptualise not only why the roles are different in the public sector but also identifies an additional influence as to why different PCT NEDs and Chairs developed different aspects of their role. I suggest that the different quadrants called for different NED skills and knowledge, which Chairs deliberately recruited for and/or developed in their NED team in response. Figure 8.2 replicates Newman's (2001) model but with my addition of the type of PCT NED skills each model called for, based on the findings of this study.

Figure 8.2: Different roles for NEDs in response to different models of government (adapted from Newman, 2001).



The self-governance model sees a sharing of power with local communities and patients. This is a long-term process which required NEDs able to build the relevant relationships and motivated to empower these local stakeholders to have a voice. The 'pull' towards a self-governance model with more public participation was legislated (Health and Social Care Act, 2001; NHS Act, 2006) but the power of the public in decision making was countered by the strong pull towards its diagonal quadrant, the rational goal model. There were few examples in this study of NEDs working towards the self-governance model, probably due to the emphasis at the time of the research on the short-term performance of the organisation rather than the longer-term and less easily measured ability of the organisation to work in partnership.

However, some Chairs and NEDs in this study, particularly those with a local authority background as an employee or councillor, took a role in moving the

organisation toward a more participative one that shared power with stakeholders, such as ensuring their voice was heard and acted upon in consultations. A clear example was also provided in Chapter Six when PCT NEDs – now facing abolition – moved to ensure that local residents had a say in where new GP premises were to be sited. As SHAs were soon to be abolished, NEDs prioritised the community in the decision-making process.

The dominant 'pull' for PCTs in this study was towards the rational-goal model, with its emphasis on performance and targets. This was a particular emphasis after the 2006 reorganisation. Chairs appointed then or after this point appeared to be more internally focused on the organisation, recruiting NEDs able to help achieve centrally-determined goals in organisational performance. NEDs were recruited who had the ability to effectively monitor executives and contribute resources where necessary. Local experience was helpful in gaining the board credibility though not seen as essential.

However, some Chairs – particularly those appointed when PCTs were first created – embraced a more networked form of governance, the open-systems model, and recruited NEDs able to help with this who could act as boundary spanners with key organisations, such as the local authority and within the voluntary sector. Chairs also spent time building up relationships and helped create the opportunities for organisations to work together in a collaborative way, organising one-to-one meetings between Chairs or board-to-board, as examined in Chapter Seven.

The bottom-left quadrant, the hierarchy model with its pulls towards continuity and order, I suggest was much less apparent in the lifetime of PCTs than the rational goal one, with its pull towards innovation and change. I have suggested that this model called for NEDs content not to exercise too much independence if, indeed in this model, organisations need NEDs on a board at all.

These influences of different models of governance meant the role of the NED and Chair in the PCT varied, responding to different Government policies that both encouraged an internal focus on board performance and short-term

measures to improve efficiency as well as external-facing, longer-term relationships to help the organisation be more citizen-responsive. In addition, PCTs were expected to work collaboratively with partners to achieve joint aims, such as reducing health inequalities. These 'pulls' could cause tensions, with some NEDs identifying a particular role in ensuring that the demands for organisational efficiency, particularly financial, were not to the detriment of these policy aims that, for example, aimed to improve public health or patient care.

This study identified three types of NEDs on PCT boards, 'the professional NED', 'the public-representative NED' and the 'public service NED'. Adding these to the NED skills suggested above (Figure 8.2), we see that the 'professional NED' and also 'public service NED' with transferable skills brought from business and other NED appointments, were able to assist the board in the rational-goal model to meet organisational targets and national performance measures. They chaired or contributed to the audit committee of the PCT and the additional time allocated to this role demonstrates the importance it was given. In Chapter Four the ability of the NED to help the PCT to regain financial balance was seen as a key contribution (albeit an easily measurable one, compared to the contribution of NEDs to other areas).

The 'public representative NED' provided some of the skills, knowledge and relationships with key stakeholders that helped the board as it responded to self-governance elements such as shared power with services users and a more-networked form of governance. These NEDs, often with other roles such as local councillors or in local government, could draw on these relationships to help develop collaborative working across organisations.

8.3 An examination of power

The examination of power has been an important one for this study, utilising the conceptual framework by Pettigrew and McNulty (1995) to examine the power of NEDs within the organisation and the different ways they were able to utilise sources of power to make a contribution. Throughout this study the relational

aspect of power has been emphasised, with the ability of NEDs and Chairs to draw on sources of power and make a difference, in line with their interests, dependent on the degree of power exercised by others in the organisation and health economy.

Non-executive directors in PCTs had clearly defined responsibilities but with limited power, compared to other actors in the system, such as the Strategic Health Authority and hierarchical accountability to the Department of Health. This study has explored some of the tensions and analysed how NEDs were able to utilise power, using a model by Pettigrew and McNulty (1995). This considers power as a dynamic process involving consideration of both structure and behaviour, with power manifest in actions (Brass and Burkhardt, 1993). It is a relational phenomenon, and the findings of this study show that when considering the power of the PCT board and NEDs this was influenced not only by their own behaviour but also by how power was exercised by others within the health economy. Therefore, when it came to intra-organisational matters, such as purchasing decisions, the NEDs had authority to act and for their position to be respected. However, when the SHA required PCTs to provide finance to other parts of the health economy, then NEDs had very little power to call upon to resist, even if they felt it detrimental to their own organisation and community.

The will to act and different sources of power

In Chapter Four it was identified that just under half of the NEDs had a strong identification with patients or the local community. These are the 'public-representative NEDs' previously described. Their contribution to governance was in ensuring these interests were promoted and defended. This provided a motivation – a will to act on behalf of these stakeholders – and is one important factor when considering how power may be utilised by board members (Pettigrew and McNulty, 1995). As first discussed in Chapters Five and Six, particular sources of power for this group were the information gained and presented to challenge managerial accounts as well as key relationships across the health community, such as with the local authority. The circumstances

where this group of NEDs was likely to be able to exercise power and to challenge managers were when current performance in the provision of services or future plans were perceived as failing to meet fully these stakeholder interests. Examples included concerns regarding future hospital provision (p.124) or current GP services (p.139).

The findings of this study identified an additional type of NED, the 'public service NED', who had a private sector business background but whose interests appeared broader than with local stakeholders and to include the general taxpaying public. There was a strong association between this group of non-executive public servants and values, such as '*giving something back'* to society. Sources of power for these NEDs arose from their professional knowledge, skills and credibility brought from their professional background. They were particularly able to exercise power in circumstances where there was a low level of experience within the senior management team or when facing a crisis, such as the organisation being in financial deficit.

Throughout the lifetime of PCTs there was a perception, particularly from GPs, that PCT boards acted as corporate rationalisers, with NEDs from business backgrounds appointed to support this process, being more supportive of managers than of patients (Hogg and Williamson, 2001; Williamson, 2008). This study shows those NEDs from business backgrounds saw a particular role in helping the PCT become more efficient and effective in its operations. However, while those from business backgrounds – and particularly those with a background in the NHS – may have been more supportive of managers and describe a more collaborative relationship than those from other backgrounds, this study does not support a view that they supported a rationalisation process above the needs of patients or the public.

Rather, in their accounts, NEDs present a role where they champion and defend these stakeholder interests against moves by managers that might have adversely affected patient care. It is acknowledged that these are self-reports and also that it is difficult to ascertain whether their intervention did make a difference. Nevertheless, their reports do not support the view that NEDs

supported financial and activity targets above quality and safety considerations (Williamson, 2008, p.516).

A question that appears not to have been posed or researched before is why people may choose to take on a NED role in the NHS, which is poorly remunerated in comparison to the private sector, and what the incentive to take an active role may be, rather than just acting as a 'rubber-stamp' for managerial decisions. The findings of this study suggest the salience of this public service identity and, for some, a salient identification with local stakeholders not only provided values to guide behaviour but also gave NEDs a stake, an incentive to act to because of the potential harm or benefit the actions of the PCT could bring to the social group with which they identified.

This incentive to act may be one influence on effort norms, which sees the NED proactively seeking additional information and preparing for meetings. A strong theme identified in analysis and a finding for this study was the proactive behaviour of NEDs in creating opportunities to gain and probe information outside of formal board meetings and committees. Acknowledging that these are self-reports, NEDs appear to have exerted high-effort norms to address the information asymmetry with managers, an aspect unexplored in other accounts of NHS governance (Abbott *et al.,* 2008; Veronesi and Keasey, 2010, 2012).

However, having identified that NEDs had a motivation to act and sources of power to draw upon, a further consideration is whether they were able to use this power to make a contribution to effective governance. It has been noted that power is relational, that is, while NEDs may have had power – and this section has identified some of these sources of power – other players may have had greater power to achieve interests important to them.

The exercise of power and influence

A strong theme from this study was that the power of the PCT board was perceived as being curtailed by the greater power of the SHA, which had both coercive power and reward power (French and Raven, 1959), and could

influence managers through threat of sanction or promise of reward, such as career progression. In a noteworthy difference to corporate governance as exercised in the private sector, the executives on the board also had to account for organisational performance to another organisation, the SHA.

The findings of this study confirm a narrow participative decision space for the PCT board regarding national policy implementation (Exworthy *et al.,* 2010), with NEDs more successful in challenging timescales rather than substantive policy. This was particularly apparent regarding the national policy directive to cease direct provision of community services, discussed in Chapter Six.

One finding from this study, significant when considering board behaviours, was the distinction made by respondents between NEDs and managers as two distinct groups on the board. Knapp *et al.* (2011) suggest the strength of this distinction is influenced by context. This study may reflect the context at the time of the interviews with NEDs and managers perceived as working to different goals, the latter implementing Government policy and with an eye to their future careers, the former concerned for the continuity and safety of services in a time of transition.

However, throughout the accounts and including reflections on earlier experiences as a PCT NED, a consistent theme in analysis is that the NEDs saw themselves as a distinct group on the board, rather than part of a team with executive colleagues. In a key difference to Vandewaerde *et al.'s* (2011) definition of a team, NEDs in the PCT did not consider the board necessarily to share a common goal but sometimes to work to different interests.

This situation appears to have influenced how NEDs exercised power and influence within the PCT. Compared to studies within the corporate sector (Pettigrew and McNulty, 1995; McNulty and Pettigrew, 1996), NEDs in PCTs appear to have used power less, where this is seen as a negative tactic, related to sanction or reward (Lucas and Baxter, 2012), and to have preferred methods of influence.

This may be due in part to differences in the types of decisions NEDs in the NHS are involved in. Crucial issues for NEDs in the private sector of the selection, remuneration and termination of appointment of the Chair or Chief Executive (McNulty and Pettigrew, 1996) are rarely the sole prerogative of the NHS board but for PCTs involved the Appointments Commission and the SHA, with remuneration largely a national matter.

I would suggest, though, that there are other reasons for the greater use of influence methods by NEDs in this study, where influence is perceived as convincing people the course of action proposed is the right thing to do (Lucas and Baxter, 2012). These factors included the norms that guided behaviour at board meetings, where overt signs of conflict were discouraged and the situation within PCTs where executive directors were perceived as possibly being conflicted between the demands of the SHA and the desires of the board. NEDs mainly utilised influential methods to persuade managers rather than directly opposed them through assertive behaviour or blocking proposals. Lucas and Baxter (2012) note that these uses of power have a secondary outcome, in addition to obtaining what one wants, which is that it can cause resentment by those without power.

This study has found the relationship between executives and NEDs to be an important one, where NEDs avoided an ‘us and them’ dichotomy on the board but sought a relationship where support and trust were held in tension with challenge and accountability. The importance of this relationship might mean that NEDs consciously chose not to exercise power with possible subsequent negative consequences, but sought other ways to influence that would maintain good relationships.

However, there were more overt signs of conflict in the accounts of NEDs and Chairs when the board’s wishes clashed with the SHA, such as regarding financial aid to other trusts or the implementation of national policies in a proscribed manner and timescale. In these instances, the ability of the NEDs and Chairs to exercise power or influence appeared limited compared to the SHA.

While the SHA may have appeared to have greater structural power, structural considerations of potential power sources cannot be separated from behavioural ones; structures arise from the actions of people (Brass and Burkhardt, 1993). So when considering the power of NEDs, the use of power is both constrained by structure and context but also contributes to them, which then in turn further constrains or enables action.

This was best exemplified when considering the accounts of PCT Chairs where previous exercise of power in the relationship between PCT and SHA changed the dynamics of the relationship and the exercise of power in subsequent encounters. Some Chairs appeared to have greater autonomy than others and while factors such as personal ability and context will play their part, it also appears to be the case that the more these Chairs exercised their power within the system the more their subsequent power increased.

However, once the abolition of PCTs was announced, the situation changed. The 'shadow of the future' (Axelrod, 1984) was lifted and altered the conditions for co-operation between PCT NEDs and Chairs and the SHA. For many Chairs this appeared to be to their loss, with their power in the system diminishing once they were no longer seen as key players. However, in a few PCTs, the power of the NEDs seemed to increase once they were no longer at risk of retribution from the SHA and, with the PCT board soon to be abolished, the relationship with executive directors no longer was the priority it may have been.

By using power tactics such as blocking proposals and forming coalitions, NEDs and Chairs in places defied the SHA, such as insisting business cases be approved for new primary care premises or measures to protect partnership working. A possible motivation to act in these circumstances arose from a public-defender role for the NEDs and Chairs, determined to protect the interests of stakeholders.

Newman's (2001) governance model of governance proves useful here. While the 'pull' towards the demands of the rational goal model and hierarchical

accountability remained, with the key player – the SHA – soon to be abolished, then Chairs gave greater attention to local organisations and communities that would outlast them and which have greater importance in the more devolved and diverse models of governance.

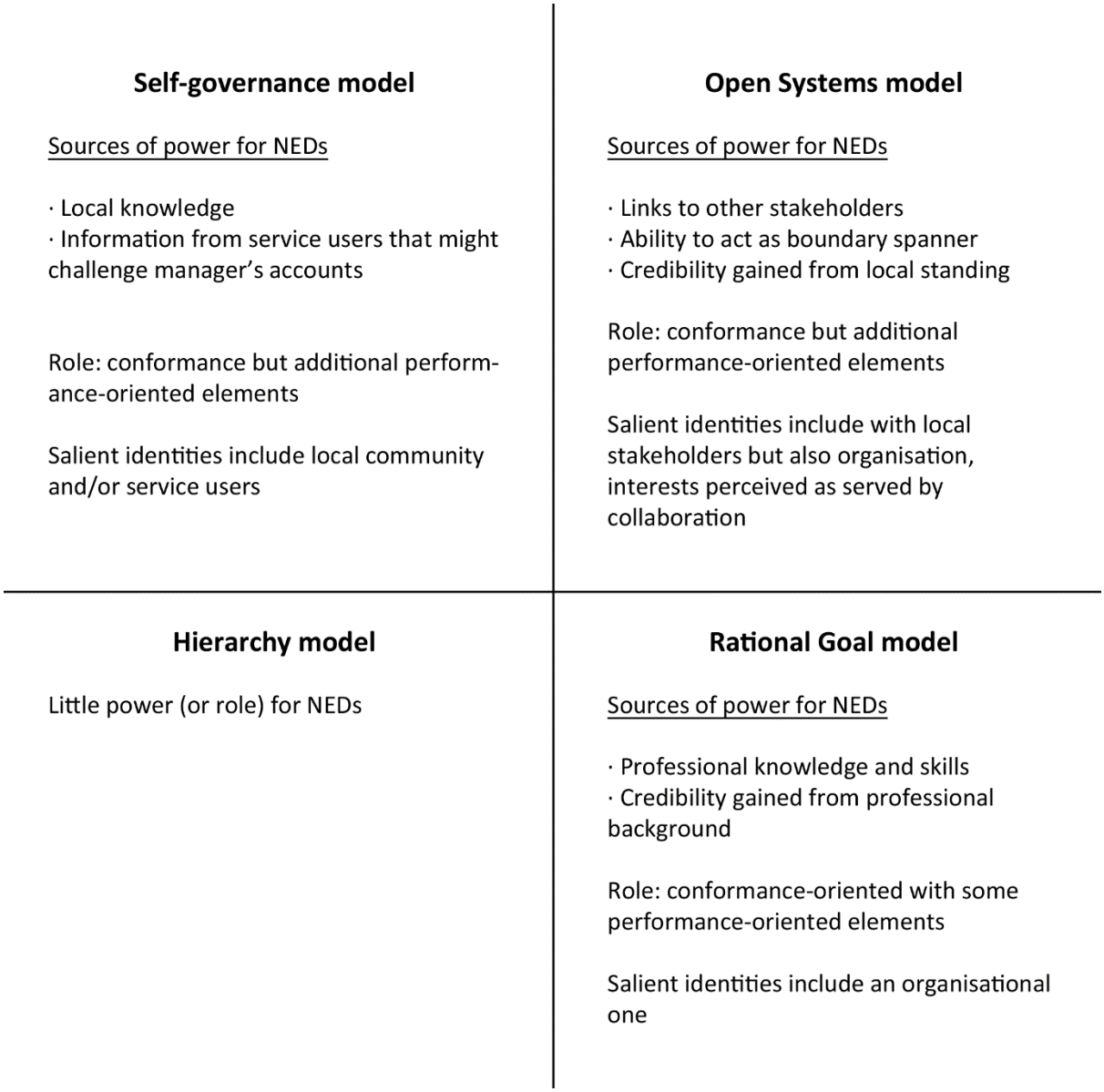
As well as the model by Pettigrew and McNulty (1995), the consideration of power is an element of the other conceptual frameworks used in this study, particularly Newman's (2001) which considers shifts in power due to changing Government policy. She suggests that rather than a hollowing out of the state, the policies of New Labour led to the 'dispersal of state power across new sites of action augmented by new strategies and technologies' (2001, p.168).

While PCT boards may have had some power, the findings of this study confirm that state power continued to be a major force, disseminated from the Department of Health, through to SHAs and to the NHS Trusts in their region. The use of performance indicators to shame the PCT if it performed badly against national targets, as this study found, was another form of state power that suppressed local autonomy (Newman *et al.,* 2004). However, this study has considered how structure and context not only shape action but are also themselves shaped and influenced by it. The actions of some PCT NEDs and Chairs led to the achievement of decisions felt to be in the best interest of local communities, despite the opposition of the SHA, by actively gaining influence with the support of stakeholders, whether medical professionals or local communities. This then set the scene for further interactions when the PCT could have greater influence.

The insights for this study from social-identity theories are also relevant when considering power. Social identity theories suggest that those perceived as fellow in-group members have more influence than those perceived to be out-group members, and people engage in strategies to protect the interests of their in-groups (Tajfel, 1986, quoted in Lucas and Baxter 2012, p.64), so providing the will to act, part of the analysis of power by Pettigrew and McNulty (1995) in corporate boardrooms.

Figure 8.3 integrates aspects of the four theoretical frameworks used for this study in the light of its findings. For each quadrant of Newman's model, and further to figure 8.2 depicting the NED skills each model called for, I have added the sources of power for NEDs identified by this study and possible salient social identities which provided a motivation to act to protect those interests. I hesitated at including social identities, mindful that these are fluid and their salience or strength of identification is influenced by context (Augoustinos *et al.,* 2006). It is also possible for people to have several salient identities. So while I present an organisational identity as beneficial within the rational-goal model which seeks organisational success (as in the attainment of performance indicators), a NED may also have a strong identification with a stakeholder identity, as some did in this study.

Figure 8.3: Different roles, sources of power and salient identities for PCT NEDs in different models of governance (adapted from Newman, 2001).



Other studies that have considered the NED role in the NHS have found a lack of clarity around the role (Veronesi and Keasey, 2010; Storey *et al*., 2010). A contribution of this study is its utilisation of different conceptual frameworks to suggest that, rather than a uniform role, the NED role varied in response to personal cognitive factors and an external policy environment that was sometimes conflicted as to the type of governance model the PCT should be operating towards, with unrealistic expectations as to what NEDs could achieve within this. It demonstrates ways the NED and Chair role could have different emphases than found in the private sector, and the different tensions pulling the

PCT toward a more decentralised and local organisation, or one operating within narrow, centralised parameters.

The model is also a helpful one as it acknowledges the tensions caused by competing models of governance that were in play and received different emphasis throughout the lifetime of PCTs and the difficulties this presented for boards. An area of interest for this study to explore was the tension for NHS boards between acting in the local interest when also required to meet national policy directives. It has found that the presence of 'public-representative' NEDs and their ability to draw on sources of power, such as their local knowledge and key relationships, were able to help the board act in more locally-responsive ways.

However, state power exercised through the creation of national performance targets and the hierarchical accountability of PCT executives to the SHA meant that most the time this triumphed over local interest when this clashed. This was seen with regard to the Darzi centres in Chapter Six, for example. While there were some notable exceptions where local interest triumphed, these were few in number and appeared more likely when the PCT was able to draw on the power of other stakeholders and also once the end of PCTs and SHAs was in sight, so the power of the latter was diminished.

The tensions between national priorities and acting in what is perceived as local interests have remained to this day even though PCTs have been abolished. There remain tensions between the accountability of the NHS organisation as a single entity and the needs of the community, which are best met through collaborative working across organisations. The implications for current practice will be considered next.

8.4 Contribution and implications for practice

When this research began, the future of PCTs seemed secure. However, following a General Election the new Government announced the abolition of PCTs and that new structures were to be set up to replace them. The

researcher, a NED herself, was therefore afforded a rare opportunity to gain insights into how individuals responded in a time of great organisational change, adapting their role as they saw fit and in the absence of new guidance during this period of transition.

PCTs had been, some would say unduly brutally, criticised as having failed in their role as commissioners (House of Commons Health Committee, 2010) and there had been a General Election in which the dire financial position of the NHS had been a major issue. The accounts of NEDs in this study emphasised their monitoring role and challenge to managers, and the part they had played in ensuring the organisation achieved financial balance, which may reflect the high political profile this had at the time of the interviews.

NEDs gave an account of their role that played down their involvement in strategic decision making, attributing greater responsibility for this to central Government than the board and perceiving they could have done more for local people but for the SHA. It may be that these were the aspects NEDs wished to present to me as a researcher and fellow PCT NED at a time when PCTs were under political fire for having failed to achieve their goals as local organisations (NHS Confederation, 2013).

A particular contribution of this research is the use of a model by Newman (2001) to explore tensions within the NED role in practice. While these tensions in the NHS NED and Chair role may have been noted in previous research, my use of the model by Newman (2001) has provided a useful lens to examine these and to consider *how* the external governance context influences the internal governance role. The hierarchical accountability to the SHA and up to Government was found to be the dominant one, with the power of NEDs and Chairs limited. While acknowledging this, NED and Chairs were able to draw upon different sources of power to achieve some successes in an overarching role as a defender of the public interest.

NEDs and Chairs remain on unitary boards in NHS hospitals and other public sector organisations, with regulatory requirements for organisational efficiency

and financial balance supporting the rational goal model (Newman, 2001). Yet the system continues to exert pulls towards greater collaboration, akin to the open-systems model, as indicated by the recent announcement by the Chief Executive of NHS Providers that 'the NHS is changing from a focus on individual NHS institutions to integrated local health and care systems' (Hopson, 2017). This follows the creation of Sustainability and Transformation Partnerships, which are expected to transform how local health and social care are delivered (Ham *et al.,* 2017). However, the emphasis on organisational efficiency is sometimes at odds with the need to work across organisations and share resources and accountability for outcomes. Thus, the tensions between the rational goal model and the move towards an open-systems one remain, with NHS boards needing to work within this tension.

The use of Newman's (2001) model to explore and explain this tension in practice and my application of it to the corporate governance role, is a particular contribution of this study with practical implications. This study identifies different roles for NEDs and the value of these in helping the organisation respond to external changes that call for more networked or citizen-responsive forms of governance. I find the value of having on the board a mix of NEDs, those able to contribute business skills and expertise and the 'public-representative NED' helping the organisation by acting as boundary spanners, able to develop relationships with key stakeholders for the benefit of local communities and patients.

A further key contribution is the identification of the importance of a public-interest commitment, which may be expressed either as a local public representative or a public servant working in the national interest. Both identifications provide a motivation to act with an overarching role as a defender of public interests. NHS boards have continued to seek NEDs from the private sector who have the skills they feel will help achieve organisational efficiency. However, this study shows that the professional skills and experience should not be the only requirement. The identification with public service is an important one that increases effort norms, provides a motivation to utilise

sources of power and influences NEDs to adapt their role as they see necessary to protect or promote the interests of those they feel they represent.

I would suggest – and this is an area for further research – that previous studies of governance in the NHS have given insufficient weight to the public-service aspect of the NED and Chair role, and whether NEDs and Chairs interpret this as serving a local public interest or a broader, national one. This notion of 'publicness' is an important contribution of this study, which is underdeveloped in studies to date on boards in the NHS and an important one when considering board composition and with implications for recruitment.

There have been few empirical studies of boards in the NHS. Chambers *et al*. (2017) update their 2013 critical synthesis of literature to consider healthcare boards. The review remains heavily reliant on research from the private sector, and concludes that there remain gaps in understanding of the skills and background needed to be an effective healthcare board member. This research helps fill that gap.

Earlier in this chapter I suggested that a one-size-fits-all approach to the NED should be abandoned, considering the benefit to boards of NEDs appointed for specific skills and knowledge, able to fulfil a monitoring and resourcing role, and others who have a salient stakeholder identity and are able to represent the public voice. I suggest that the needs of NHS organisations will vary and at times the board may need more of one type of NED than another. To focus on the 'professional NED' to the exclusion of the more public-representative one, may limit the board's ability to respond flexibly to suggested new ways of working, as envisaged in the Five-Year Forward View (NHS England, 2014).

A further area of contribution of this study is its exploration of behavioural dynamics of boards in the public sector and particularly the use of power, using a theoretical model suggested by Pettigrew and McNulty (1995). The power of the NED and Chair in this study was curtailed by the limited decision space available to them. The import of the role from the private sector without fully considering the different context and accountabilities has been found to cause

tensions in practice. The accountability of the executive members of the board to both the SHA and the board meant that the NEDs needed to exercise particular skills in influencing, rather than the overt use of power, to achieve their goals. The findings on power help contribute to an understanding of how a NED can contribute, and the skills needed to achieve this within a complex environment of power relationships.

Accountability remains a key tension within the health services. At the Labour Party conference in the autumn of 2017 it was stated that if voted into power the Labour Party would increase the accountability of NHS organisations to local people (Scott-Samuel, 2017). The democratic accountability project that first sparked this research appears to have come full-circle. At that time, a suggested way of addressing this 'democratic deficit' was to involve local people in the appointment of PCT Chairs. However, this study has demonstrated the tensions experienced by the boards of local NHS organisations working within a strong hierarchical system of accountability. To change the appointment process of Chairs or NEDs, or even to move to the election of NEDs, would fail to address the tensions in the system. Local accountability, I suggest, can only be served by a different form of governance. In the meantime, this study suggests that the needs of local communities and patients are best served by NHS NEDs and Chairs able to work within these tensions, motivated and able to work collaboratively across and between organisations, some with additional requisite professional skills but above all a motivation to defend the public interest and so to mobilise those sources of power available to them.

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Appendix A: Roles and Responsibilities of the Non-Executive Director

As a non-executive director you will work alongside up to six other non-executives and seven executive directors as an equal member of the board. You will share responsibility with the other directors for the decisions made by the board and for the success of the organisation in leading the regional improvement of healthcare services.

Your role as a non-executive will be to use your skills and your personal experience as a member of your community to:

1. Contribute to the development of strategic plans to enable the PCT to fulfil its leadership responsibilities for healthcare of the local community.
2. Ensure that the Board sets challenging objectives for improving its performance across the range of its functions.
3. Monitor the performance of the executive team in meeting the agreed goals and improvement targets.
4. Ensure that financial controls and systems of risk management are robust and that the Board is kept fully informed through timely and relevant information. (You may be asked to sit on the Audit Committee on behalf of the board.)
5. Accept accountability to the Strategic Health Authority for the delivery of the PCTs objectives and ensure that the board acts in the best interests of its local community.
6. Take part in the appointment of the Chief Executive and other senior staff (and if you are asked, to sit on the Remuneration Committee, to decide on their remuneration).
7. Ensure that the PCT values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business.

Taken from Appointments Commission (2006). *Primary Care Trusts in Greater London. Non-Executive Director Appointments.* London: The Appointments Commission. Page 6.

Appendix B. Map showing the different PCTs represented in this study.

Appendix C. The different PCTs represented by NEDs and Chairs in this study.

The year of appointment is in brackets. Some PCTs existed as pilots prior to the widespread introduction of PCTs in 2002.

To give some indication of the size of the PCT, revenue allocations for 2010/11 are provided (DH, 2008). These have been rounded to the nearest £50m to help preserve anonymity. Allocations were made on the basis of a formula that included factors such as population and levels of deprivation.

The range of annual allocations for 2010/11 was from £1,800m for the largest PCT, serving a population of 1,300,000, to under £200m for a PCT serving a population of 91,000.

South-west England

PCTs A, B and D covered large geographical areas, with allocations of £800m, £550m and £900m. PCT C was smaller (£300m).

PCT A Chair 50 (2006, previously Chair elsewhere)

PCT B Chair 29 (2009, previously Chair elsewhere)

NED 28 (2003)

PCT C Chair 48 (2001)

PCT D Chair 45 (2002)

South-east England

PCT E was the largest PCT in this study with a revenue allocation of £1,200m. PCT G, had £900m, PCT H £700m, PCT F was smaller, with a budget of £500m.

PCT E NED 34 (2010)

NED 46 (2006)

PCT F Chair 30 (2000)

NED 31 (2005)

NED 35 (2008) Audit Chair

PCT G Chair 13 (2002)

NED 25 (2006)

PCT H Chair 23 (2002)

London

The 31 London PCTs did not merge in the 2006 reorganisation. They were generally smaller in size than elsewhere in England. Allocations ranged from £550 (L6) to £250m (PCT L1).

PCT L1 NED 18 (2007)

PCT L2 Chair 1 (2000)

NED 2 (2002)

PCT L3 Chair 16 (NED 2008, Chair 2010)

PCT L4 Chair 7 (2000)

NED 6 (2008)

PCT L5 Chair 5 (2005)

NED 3 (2007)

NED 4 (2008)

PCT L6 NED 24 (2006) Audit Chair

PCT L7 NED 17 (2005)

PCT L8 NED 9 (2010)

PCT L9 NED 11 (2010) Audit Chair

PCT L10 NED 10 (2007)

PCT L11 NED 8 (2010) Audit Chair

NED 21 (2007)

Central England

PCTs I and L were larger (£800 and £900m), PCT N was a city PCT (£450m) PCT M was smaller (£250m).

PCT I	NED 41 (2008)
PCT J	NED 42 (2009)
PCT K	Chair 39 (2001)
PCT M	Chair 38 (2006, previously Chair elsewhere)
PCT N	Chair 26 (2010)
	NED 27 (2008)

North-east

PCT P was a larger PCT (£1,150m), both PCTs O and Q were smaller (£450m and £400m).

PCT O	Chair 32 (2001)
PCT P	Chair 37 (NED 2002, Chair 2009)
	NED 33 (2005, previously SHA NED) Audit Chair
PCT Q	Chair 47 (2001)
	NED 44 (2006)

North-west

PCTs R and S2 were larger rural PCTs (£850m and £750m), PCTs V and S1 slightly smaller (£750m and £550m) and PCTs T and U smaller (£400m and £300m).

PCT R	Chair 12 (NED 2007, recently appointed Chair)
PCT S1	Chair 52 (2006)
PCT S2	Chair 51 (NED 2006, Chair 2008, PCT later merged with S1)
PCT T	Chair 40 (2006)
PCT U	NED 41 (2002)
PCT V	Chair 36 (2010, previously Chair elsewhere)

North

PCT W was a larger city PCT (£850m), PCT W smaller (£650m), PCT Z had an allocation of £350m and PCT X the smallest PCT in this study (£200m).

PCT W	NED 15 (2002)
	NED 19 (2006) Previously SHA NED
	NED 20 (2006) Audit Chair
PCT X	Chair 49 (NED 2006, recently appointed Chair)
PCT Y	NED 14 (2006, previously SHA NED)
PCT Z	NED 22 (2007) Audit Chair

Appendix D: Participant Information Sheet

My research looks at the contribution of Non-Executive Directors (NEDs) to governance within PCTs. It will try to answer the following questions:

- What do NEDs identify as the key skills and knowledge they have brought to the governance of PCTs?
- What do they understand their governance role to be?
- What do NEDs see as the factors that have either enabled or hindered their contribution to effective governance within PCTs?
- What are PCT NEDs able to contribute to the successful transition of commissioning from PCTs to Clinical Commissioning Groups?

Although the abolition of PCTs is planned for April 2013 this research will contribute to the debate on the NED role within the NHS and the wider public sector. It will identify the contribution NEDs can make to governance and public accountability. It will be of benefit for Clinical Commissioning Groups as they consider the composition of their boards, the contribution an independent director can make to the work of the board and what enables good corporate governance.

Interviews will be conducted by telephone at a mutually convenient time. It will be recorded with the interviewee's permission.

Only the interviewer and interviewee will have access to the responses.

Participation in this study is voluntary and you may withdraw at any time.

Confidentiality will be maintained. The identity of participants will not be disclosed. In all written documents or oral presentations the interviewees and individual PCTs will remain anonymous.

If you are willing to be interviewed for this research please contact me on xxxx

Joy Tweed,

Department of Management

Birkbeck, University of London
Malet Street Bloomsbury
London WC1E 7HX

Supervisor

Dr Suzanne J. Konzelmann
Reader in Management
Director, London Centre for Corporate Governance & Ethics
Director, Post Graduate Programmes in Corporate Governance & Business Ethics
Birkbeck, University of London
Malet Street Bloomsbury
London WC1E 7HX

Appendix E: Interview guide

When did you become a NED?

Where is your PCT situated? (This is to assess geographical coverage. No individual PCT will be identified in the final research.)

1. Why did you decide to become a NED?

2. Before your appointment, what did you think your role on the PCT board was to be?

   (Interview prompts: Were you clear about what your roles and responsibilities were? Does the role meet your expectations? If not, how does it differ?)

3. What in particular do you feel you are able to contribute?

4. Do you live in the local area covered by the PCT on which you serve?

   (Interview prompts: If so, do you think this is beneficial? Can you think of examples where it has been really important that the NEDs had local knowledge?)

5. Do you have (or have you had) any other non-executive roles?

   If you have had other non-executive roles, how does the PCT NED role differ?

6. What in your experience is the relationship between the NEDs and the executive members of the PCT board?

7. Outside of the board, what sort of relationship do you have with executive directors/managers?

8. Thinking of the different NEDs on your board, does each of you have different areas of expertise?

   (Interview prompts: Are you able to work to these different strengths?)

9. Guidance and training – Are you aware of any guidance on the work of NHS boards?

   If so, what aspects have been helpful to you in your role?

   As a NED, have you attended any training events covering the work of the board and your role within it?

10. Have there been any occasions when you needed to seek external advice about your NED role?

    If so, where did you go for this advice?

11. What factors, if any, do you think hinder your personal contribution to the PCT Board?

    Are there any factors that particularly enable you to make an effective contribution?

    (Interview prompts: How much autonomy do you think the PCT board has had?)

12. Have you faced any particularly challenging situations as a PCT board where you felt the NEDs had a crucial role to play?

Would you be able to describe the situation to me and in particular the role of the NEDs in it?

13. Do you feel your role on the board has changed during your time as a NED?

    If so, how did it change and what do you think caused this change?

    Do you see a role for PCT NEDs in enabling the transition from PCTs to commissioning by clinical commissioning groups?

    Could you describe how you envisage that role?

14. In a few words, how would you sum up the role of a PCT NED as you experience it currently?