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**NEW GOVERNANCE ARRANGEMENTS IN THE NHS:
EMERGENT IMPLICATIONS**

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ABSTRACT

Many of the far-reaching reforms to the NHS (such as the creation of the Foundation Trusts, the creation of the new Primary Care Trusts and the creation of the quasi-market) can be seen as essentially changes to the governance arrangements. This is because the programme of reforms are transforming the NHS from a centrally-directed service to a more complex system with devolved local commissioners and a delivery structure comprised of diverse providers. These providers are increasingly being defined as 'autonomous' and they include an array of private sector and third sector players operating in an emergent market for health care. This more complex devolved and variegated system places an extra premium on governance and regulation.

The OUBS-led project funded by the NHS-Service Delivery Organisation, is charged with making an assessment of the new governance arrangements and with exploring their various impacts. The research commenced in 2006 and the fieldwork runs through until late 2009. The field research is covering all levels of the NHS including the centre, the Strategic Health Authorities, the Primary Care Trusts and the Acute Trusts as well as a number of the various regulators. This Working Paper sets out to make an early assessment of the actual developments in governance arrangements on the ground, the way they are being responded to by key players such as trust directors and senior clinicians, and the early signs of impact.

Introduction

The purpose of this Working Paper is to clarify the meanings and significance of governance in today's NHS – a moment in time when the service is being extensively transformed through the institutionalisation of new governance arrangements.

'Governance' is a term which is now used very widely in the health services; this reflects its wider use in other parts of the public services. It has been a key theme in political science in recent years; its rise to prominence is such that it has even been described as a 'defining narrative' in policy circles (Rhodes 1997). Indeed, the 'governance turn' has become so pervasive that it has even been suggested that 'new public governance' represents the latest paradigm shift displacing the much vaunted 'New Public Management' (Osborne 2006). In the NHS, 'governance' has been projected to an even more prominent position through a series of policy reforms and reorganisations which have attended to the idea and apparatus of governance in a very explicit way and at multiple levels and in diverse settings. The ideas, principles and mechanisms constituting governance in the NHS derive from an amalgam drawn from corporate governance, public governance and a variety of other sources. The resulting miscellany presents directors, managers and clinicians with a considerable sense-making challenge.

The aim of this paper and of the study as a whole is to explore the intentions and expectations of policy makers as they devise new governance arrangements, to assess the ways in which key players such as chief executives and directors of boards are interpreting the new structures and possibilities and to make an assessment of the likely outcomes. The empirical work for the project is at this point still in progress and so in this paper only some early signals can be identified and read. But, this qualifier noted, the argument of this paper is that there do appear to be some signs that governance has taken a significant 'turn' in recent years and may now be beginning to have an impact in a way on a scale not achieved by previous reform attempts.

The NHS consumes vast resources: it spends around £100bn per annum and employs approximately 1.2m people. The governance agenda, which involves controlling, managing, shaping and influencing the deployment of the associated financial, staff and physical resources, is a massively complex undertaking. The ways in which this is attempted are themselves undergoing extensive change. New ways and new combinations of ways to establish priorities, set targets, shape incentives, monitor performance and re-shape behaviour are being actively pursued. New institutions and processes are being created and new forms of accountability devised. These new forms combine elements of market disciplines with formal direction and control. Such diverse modes and combinations of governance mechanisms are generating novel challenges, dilemmas, uncertainties and opportunities.

It was in order to study the unfolding of these new and emerging arrangements that a team of researchers from a number of universities embarked on a three year study of these changes. In this study we are probing all levels of the NHS and are delving into the unfolding logics of the policy-makers, the strategists, the secondary, primary care and mental health sectors who together and in varying degrees of looseness or tightness, engage in various forms of multi-agency working (Wilkinson and Appelbee 1999). It is necessary to take such a wide-ranging view because the reforms and the

change to accountability are taking place at multiple levels and in interlocking ways. Hence, it is the dynamic interplay between them that will determine their impact and outcome.

Research methods

The core of the study so far has been based around 12 in-depth case-studies: 6 primary care trusts and 6 acute trusts. These cases have been supplemented with research within a range of institutions which set the multi-level organizational context including the Department of Health, Strategic Health Authorities, the NHS Confederation and Monitor.

The focus of the work in each of the PCT and acute trust cases has been to explore how senior players within trusts (including chief executives, non-executive and executive directors, medical directors and clinical directors) are making sense of the new governance arrangements and the practical actions they are taking as a consequence of this meaning-making. The research team will of course be reporting on specific issues in particular parts of the system, but for the purpose of this paper our aim is to present the ‘bigger’ picture – to provide an overview of the issues and the developments in a holistic way. This will necessitate a broad and general view but it will allow us to identify and clarify the key practical issues and to identify critical questions and issues for future research. The main starting question is what are the most significant of the governance changes now taking place, and how are the actors responding to the new mix of emerging principles and new rules of the game?

Organization of the paper

The paper is organised into three parts. The first part discusses the meaning of the ‘governance’ construct including what it is for and how it is done; the second part discusses changes to governance that have been occurring within the NHS; and the third part reports on key findings from our research to date and discusses their implications.

Changing meanings of governance

To ‘govern’ derives from the Greek word meaning ‘to steer’. Modern definitions variously refer to ‘rule with authority’, ‘direct and control’, and to ‘regulate’. Ways of governing can range from the despotic mode, to constitutional, technocratic or other variants. However, ‘governance’ in the modern sense tends to be associated with a system constituted by devolved bodies assuming ‘bottom up’ a range of responsibilities while subject to ‘top down’ regulations, scrutiny and oversight – a network in place of a single central controlling agent but one that is accountable to its members. All kinds of actors are therefore involved in governance, if only because ‘government’ does not perform all of the governing itself; “a wide variety of actions from different actors have consequences for governance” (Kickert 1997)p2. There is a general sense in current usage that governance is a form of legitimate authority which is not despotic, sovereign or arbitrary. Indeed, it has increasingly been used in the public and voluntary sectors to refer to the oversight of executive power; it sets the expectations for executive agents, it sets parameters, it grants decision rights and conditional authority, and it monitors performance against targets. ‘Governance’ is

constituted by a number of processes which are designed to meet a number of objectives and which are usually organised into a number of structural arrangements.

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

Policies and experiments in the realm of governance of the NHS represent a particular confluence of forces and ideas. In part they reflect a wider trend of the 'hollowing out of the state' (Rhodes 1997) across a number of services. In addition they reflect the influence of market ideology and the reform of public service provision. However, more particularly, they reflect responses to widely publicised scandals such as Alder-Hey, Bristol and Shipman. Likewise, scandals in private sector as well as public sector institutions have prompted a willingness and desire to learn from others' experiences (Benz 2007). Both Conservative and Labour governments have honed a narrative about the NHS which suggests the need for 'movement from a "failed" bureaucratic model to a system of entrepreneurial governance that would help it to survive' (Currie and Brown 2003)p.568.

The emergence of new governance arrangements can also be interpreted as response to growing social and organisational complexity – the idea that under fast-moving and complex conditions a central bureaucracy can no longer cope but requires engagement by participants at every level; the state recognises that it has to share power – a phenomenon that has been described as a shift to 'co-arrangements' (Kooiman 2003). This is reinforced by other factors: citizens are better educated and less deferential. They expect to be consulted and be involved. Increasingly they are 'challenging bureaucratic or paternalistic modes of administration' (Clark 2005 p1040. Thus, on an optimistic reading, the changes to governance in the NHS can be interpreted as moves towards more advanced modes of citizenship in which clinicians and patients are reconstituted as active participative agents, no longer 'recipients'. A less optimistic reading might suggest that the changes reflect the state's intent to exercise control and influence in more effective and fiscally-affordable ways. To a considerable degree, whatever the initial motive, the course of the outcome will be determined by the behaviour and intentions of managers, clinicians and patient representatives themselves within the devolved arrangements.

The governance structure of the NHS

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

Policy makers within the DH are well aware of the linkages between governance and the modernisation agenda. In the publication 'Governing the NHS' (DH 2003) the connection is made quite explicitly:

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

This statement places board members and senior managers at the heart of the reforms. It means that accountability is of a higher order than heretofore. Part of the relatively unspoken agenda is the desire to wrest control from doctors, especially hospital consultants, who have long been able to resist the various initiatives such as those stemming from the Griffiths Report (DHSS 1983) which sought to curtail clinicians' power. Backed by their colleges, individual doctors have largely succeeded in preserving professional autonomy, and enjoying power without corporate responsibility. The traditional notion of 'management' within the NHS therefore has been described as more akin to 'diplomacy' (Harrison 1999)p.52. The more recent changes to governance, with the admixture of plurality of providers, payment by results, clinical audit and clinical governance, greater commissioning powers granted to PCTs, and attempts to bolster the power of trust boards and chief executives, may however be cumulatively changing this long-standing state of affairs.

A whole series of organisational changes have been initiated across both primary and secondary care in England in order to facilitate the implementation of such principles and ideas. A crucial accompaniment to many of these has been a conscious attempt to build-in formal governance arrangements. These include for example, the accountability of Foundation Trusts to their Boards and, through them, to their Governors and in turn to local citizens through Membership structures. Supplementing these are the elaborate arrangements for monitoring, regulation, standards and inspection. Such governance structures and processes cover not just corporate boards but also clinicians through parallel arrangements for overseeing clinical practice through clinical governance procedures.

In total, NHS staff including Directors, managers and clinicians of all types, find themselves in the middle of an array of new structures, procedures, standards, and targets. They are variously expected to conform to given standards, to meet given targets, to act in business like ways by competing and making a surplus, to abide by professional codes, to cooperate and participate in professional networks. These cross-cutting regulatory systems combine elements of command and control, bureaucracy,

markets and so on. The diverse demands can seem bewildering. They are in market-like situations but there is no real market (Bate 2006); prices, for example, are fixed by tariff and are not elastic. In total, the system seems to comprise quasi-bureaucracy, quasi-markets and quasi-networks. The fascinating question is what the key players in the system – directors of primary care trusts and hospital trusts as well as other potential providers - are making of all of this in practice. To which of these ‘drivers’ and ‘incentives’ will they, are they, responding?

Governance issues emerge in relation to many different types of decision making. These may range from major strategic decisions such as the core mission of a trust, its intended size and shape, its new service configurations, mergers and acquisitions, hospital closure, or other significant matters of scale, or it may be a clinical procedure or a special project, through to the routine cycle of operations and their monitoring and reporting. Public confidence issues, media attention, regulatory and judicial scrutiny all contribute to a continuing focus on accountability: who makes decisions, how they are made and how they are disclosed.

At the national level, devolution of much healthcare policy to the national administrations of Scotland, Wales and Northern Ireland has resulted in variation in governance patterns and indeed in different policy outcomes as a result of decisions taken by these different governance bodies. In this paper we will focus on the English NHS which consists of a number of different layers or levels of governance structure.

At or near the pinnacle of the governance pyramid is the Department of Health (DH), the policy-making department of state which is sensitive to the political dimensions of national healthcare. Indeed health is such a major political area that each of the main cogs of government including the Cabinet Office, the Prime Minister’s Policy Unit and the Treasury tends to get involved in the NHS and each has its own policy preferences. Officially, the DH is the political master of the NHS but there is a blurred boundary between the DH and the senior echelons of the NHS. The chief executive of the NHS is not a career civil servant but like his predecessors, he rose through the ranks of the NHS management training scheme and career structure. There are often tensions between the DH and the NHS secretariat in that the latter do not like to see themselves as merely following the politically-driven priorities of the department. Hence, who ultimately ‘governs’ the NHS at the very top is itself a moot point.

Below the central NHS, and the next level down, the Strategic Health Authorities (SHAs) act as the arms of the Department. There are currently 10 of these in England and in the main they map on to the English geographical regions. The SHAs each has a Chief Executive, a Chair, and a Board. Their main function is to be responsible for the various NHS organisations within their territories. This means they are supposed to plan, transmit messages from the centre and monitor performance. They allocate budgets and do have some discretion in moving budgets around if some trusts are in deficit and some in surplus- though in recent times this has become a highly sensitive issue as each trust must, as a priority, be financially robust and failing trusts will have turnaround teams sent in to ensure that this is achieved. Senior managers’ jobs – and even chairs of trusts – are at risk if they neglect financial balance. There is some ambiguity and uncertainty at this level about the power of the SHA chief execs.

At the level below the SHAs are the organisations which commission health services (the Primary Care Trusts) and those which deliver it (a variety of providers). Apart from their commissioning duties, the PCTs also currently provide primary care services but, in future, the plan is that they will divest themselves of direct provision of services and will focus on commissioning. Commissioning is, increasingly, the *raison d'etre*.

At trust level, overall governance is effected through sets of arrangements based on models borrowed to a considerable extent from the corporate world. Trust Boards have long been established, each comprising Non-Executive Directors, a Chair and a Chief Executive. In the case of Foundation Trusts, extensive guidelines detailing how these bodies should be structured and should behave in order to mimic 'effective boards' have been promulgated by the Appointments Commission in conjunction with Monitor and Dr Foster Intelligence (2003; 2006; 2007). The guides state the purpose of NHS boards: to set strategic direction, to oversee progress towards strategic goals and to monitor operational performance' (p1). Additionally, they define the principles which should guide how each of the organisations (SHAs, acute trusts and PCTs) should operate, stipulate the role of the boards, outline the precise information requirements needed in order for boards to discharge these responsibilities, and provide model board agendas and an annual cycle of board activities. In other words, there is very considerable guidance, and thus scope for, relatively uniform practice. And given that trusts are overseen and judged by the bodies issuing these guidelines there is considerable incentive to take serious note of their suggestions. Foundation Trusts need to satisfy Monitor (the independent regulatory body) that they have in place systems and procedures that meet their criteria.

In addition to the guidance about procedures there are numerous other external audits of performance outcomes. Of great importance here is the Healthcare Commission which evaluates performance against a detailed list of 'standards'. But at the theoretical axial point is the notion of 'corporate governance'. This denotes the machinery and processes at Board level which are designed to allow supervision and policy direction of trust management in primary and secondary care. The intense concentration on Trust Boards in recent years including, for example, the focus on building 'effective boards' is indicative here, see for example, (Sonnenfeld 2002; Bevington 2004). And beyond the Boards per se, the creation of semi-autonomous 'Foundation Trusts' with their own governing bodies with Trust 'Governors' and 'Membership' and the increased autonomy and freedom for Strategic Health Authorities would be an example. Again, the extent to which initiatives in this area are delivering value for NHS trusts – in terms of for example, safety, quality, and so on, is an empirical question. Corporate governance is a phenomenon that sits above and oversees 'management'. Its main manifestation is to be found embodied in the Board of Directors including Non-Executives as well as Executive Directors. Their joint role is to assume corporate responsibility, to undertake risk management and to assume responsibility for the financial viability of the undertaking as well as its performance outcomes.

'Clinical governance' occurs within the envelope of corporate governance. In essence, it refers to a series of protocols, institutions and processes which are designed to help ensure that there is some oversight of clinical judgement, practice and outcomes. Individual clinicians and clinical teams are thus held to account for what they do. In

recent years, trusts have appointed directors of clinical governance and have established clinical governance committees. Whether this is conformance ritual or genuinely useful risk management is a question discussed below.

Many of the reforms to the NHS over the past two decades, beginning with the Conservative Government's introduction of the internal market and experimentation with GP fund-holding in the early 1990s, through to New Labour's post-1997 reforms can be interpreted as shifts in governance arrangements. Today, Trusts are assumed to have attained or to be working towards 'Foundation Trust' status; therefore, they are expected to adopt a 'business-like' approach, which in turn means they need appropriate information and the ability to take a strategic approach. The new rhetoric of the NHS is about moving away from a 'provider driven' service to one which enables greater patient choice and a focus on improving patient experience. As a result of this new framework trusts are expected to focus on 'market and business development in the context of patient choice and payment by results; boards increasingly need to think in terms of understanding their trust's markets, analysing the competition and developing the trust's business' (Appointments Commission 2006 : 8).

While the various levels of governance differ in a number of important respects they also share some common attributes. Each one pays regard to the notion of accountability, they all build machinery to ensure regular oversight and review, they set guidelines and monitor performance against targets of process and outcomes, and so on. We contend that it is useful and important to attend to all three types and levels of governance. They each interlock with the others in a system of relationship interdependency and mutual influence. It is because this macro-level governance architecture has been redrawn – for example through the introduction of quasi-markets, the granting of relative degrees of autonomy for trusts, and the occasional prompts to encourage collaboration - that meso-level actors (trust boards, chief executives and chairs of boards etc) are faced with the opportunities, threats and dilemmas that are now so characteristic of today's health service management.

Responses and issues arising

How are managers and healthcare staff interpreting and responding to these reforms in general and to these new opportunities and systems of governance in particular?

It is rather too early both in the programme of reforms and in our study of them to make any definitive statements about impacts, but we can discern some emergent trends and we can state some propositions for future analysis. The main issue arising in our study is the actors' interpretations of the rules of the game – and indeed the nature of that game. Directors of trusts are working within a system or set of systems comprised of multiple principles and multiple drivers. Knowing how to play multiple games at once is a skill in itself. The various reforms to governance constitute an admix of rules, institutions and ideologies simultaneously involving central direction, local accountability and professional agency. The way in which the actors make sense of, and navigate their way through, the cross cutting principles and the multiple reforms is a critical issue. The indications so far are that, despite the elements of devolved powers and responsibilities, the centre continues to exercise influence in many very significant ways.

First, centrally-determined targets and priorities remain the main concern of directors. Indeed, with good reason, for, in those cases where central targets and goals are ignored or not met, there are exemplary lessons where chief executives and chairs are summoned to receive very clear directions. Failure to accord with central wishes can result in directors being replaced or at least subjected to the imposed authority of turnaround teams. The average tenure of a chief executive is widely believed to be just 2 years.

Second, the key local actors are carefully selected in the first place so that the potential for opposition to central agenda is minimised at the outset. For example, Non-Executive Directors of PCT Boards are recruited and selected by the Appointments Commission. There was a perception among board members in our study that the kinds of people appointed to the newly reconfigured PCTs were of a different kind than had previously occupied these positions – the seeming new ideal was a person with considerable business and financial experience in the private sector. Apart from the actual staffing of the boards, this pattern of appointments has also sent a message about expected priorities. The PCTs have been recast as the instruments for reshaping healthcare provision through their design and commissioning functions. In the past couple of years as the government gave massive priority to eliminating budget deficits. These messages fitted well with the new appointments which appeared to shift from erstwhile community representation and health service experience to an emphasis on financial management skills. Indeed, the huge, single-minded focus on finance and the need to make a surplus was indicative of the extent of the retained command and control governance mode. Putting the question of rights and wrongs of the matter to one side, the fact is that trusts which had for years found that deficits were tolerated now had to learn the new rules of the game. Meanings had shifted decisively.

Third, the multi-tier governance apparatus in the NHS can also be seen in the way in which the multiple institutions interlock. The mix of autonomy on the one hand for provider trusts and indeed for the commissioning trusts (PCTs) and on the other hand direct control and priority-setting by the centre is notable. In addition, there is the crucial role played by the regulatory bodies. The independent regulator for foundation trusts, Monitor, was perceived by directors of trusts to wield very considerable influence. Directors sought to anticipate Monitor's requirements and expectations and tried to ensure conformance with them. Likewise, the standards stipulated by the Healthcare Commission (HCC) were regarded as the priority targets by the trusts. To a very large degree, these trusts could be considered 'well-governed' if they managed to meet the standards and targets stipulated by Monitor and the Healthcare Commission. For some trust boards additional objectives seemed subsidiary to these; but other trust boards seem to be more ambitious.

The HCC inspects both hospital trusts and PCTs. It plays a part in governance in the sense that it wields delegated powers from Parliament to set standards and to ensure compliance with standards. It can and does set new priorities for Trust Boards. As a consequence, we found that Trust Boards in the main were using these standards as their prime objectives. Hence, there had been devolved 'accountability'. An example of just such a recent shift in priority is the way the Healthcare Commission's blueprint for the annual health check 2008-09 has stipulated that primary care trusts will be

assessed on the quality of commissioning. This follows criticism of PCTs' commissioning skills. The Chief Executive of the HCC has stated that: "The commission wants the assessment to be more focused on clinical quality". Under the plans, trust boards will have to declare whether they have complied with the 24 national core standards for their commissioning and providing functions.

But, having noted the extent and nature of continued influence from the centre, it is necessary to also note recent changes in the extent and nature of the working out of local autonomy. The design of Foundation Trusts gave them new status as separate 'businesses' with devolved accountability for profit and loss, income and expenditure, and ultimately responsible for their own survival. But, although freed from the dominion of the SHAs, the Foundation Trusts have, to date, found their independent role somewhat uncertain and paradoxical. On the one hand, they have been urged and encouraged to identify and develop areas of expertise and competitive advantage, while on the other hand there is an expectation that they should not be 'predatory' with regard to neighbouring trusts in a way which might render them non-viable. Likewise, there is an expectation that although competing, they should also be cooperating in the interests of the wider health service and health economy. While that *idea* of 'cooperation' remains a persisting expressed 'value' its meaning in terms of areas for cooperating and the extent of cooperation remain problematical. The same applies *vis a vis* the relations with the PCT: again there is a dual relationship – this time of contractor (implying hierarchy) and of partner (implying equality). There is a further contradiction. FTs are supposed to make their own way and, to a certain extent, be entrepreneurial, but they operate within a set of constraints which make it difficult to withdraw from service offerings – including those revealed as loss making.

Within trusts, the development of devolved accountability to service line level reveals similar paradoxes and tensions. Under pressure from Monitor, Trust Boards have been encouraged, even required, to ensure transparency on income and expenditure, profit and loss for each service line. At minimum, this means service line reporting, but there is also additional pressure to develop this into service line 'management' (i.e. active devolved managerial accountability) and even the creation of 'profit centres' and business units at clinical directorate level. The behavioural responses by directors, managers and senior clinicians so far have been varied. Managers have been keen to promote transparency and indeed to devolve accountability, but they have also been circumspect about devolving too much power. The kind of accountability they carry (as noted above) makes them nervous about devolving decision making to lead clinicians with little proven track record in the business management arena.

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

For their part, clinical directors have in the main accepted the principle of devolved accountability for income and expenditure while at the same time the have often been

highly questioning about the reliability of the income and expenditure data. Practice to date with regard to this potentially very significant change to health care governance has been experimental and guarded. The general pattern so far, however, has been for clinical directors to be enthusiastic about the prospect of taking charge of devolved business units. To this extent, 'clinical engagement' has not been too difficult. The problem rather has been that boards, most notably, chief executives and finance directors, have been reluctant to relinquish their control.

The introduction of such business units has introduced a new tier to the cascade of governance. These units potentially become semi-autonomous governing entities; the extent to which they do so already varies considerably in practice both between trusts and between different units within trusts. But all clinical directorates are subject to oversight mechanisms. They are held accountable by more senior Trust-level management – usually including their own Medical Directors. A typical reporting structure is for each unit to report to a scrutiny committee comprising a Medical Director and a Finance Director on a regular basis – perhaps every two months. At these meetings a scorecard of multiple measures and performance indicators for units are reviewed and discussed. Trends can be identified and any corrective measures identified. New targets are set. In turn, the total set of measures and performance indicators are often made available to the Trust Executive on a regular basis and the cumulative data presented to the Trust Board, Monitor and the Healthcare Commission.

Interpretations, conclusions and the research agenda

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

There are a number of indications of such difference. The scale and the multi-layered nature of the changes provide a set of mutually-reinforcing drivers. There is considerable professional expertise within the system. Monitor and other bodies have recruited staff with high levels of talent and they have produced tools which are persuading many management teams to adopt them. The Appointments Commission launched in 2002 has taken steps to ensure that persons appointed to senior positions in trusts are of high calibre and broadly share the values of the change programme. In addition, their agendas are likely to align more closely with those Medical Directors in the larger trusts who have taken on full-time roles as director-managers and relinquished their clinical practice. Others senior clinicians who are working half time as divisional clinical directors may also increasingly adopt a more entrepreneurial role in relation to their divisions and directorates.

Of course, despite the number who were committed to the role and who had the calibre to fulfil the role there were others whose attitudes more closely reflected those

found in previous studies – ambivalent, essentially committed to the clinical role, reluctant to manage other clinicians and so on (e.g. (Dopson 1996; Ferlie, Pettigrew et al. 1996; Hoque 2004) (Pollitt, Harrison et al. 1991)). However, this time around, our study is revealing that there are a number of key differences. One is that those trusts which are leading the change are taking steps to remove the less committed consultants from clinical director roles, and they are only able to do this because they have located a sufficient number of consultants willing to undertake the role in the fuller sense. It is true that there is no surfeit of these candidates but still significant that there are beginning to be at least enough to talent spot and develop. Much hinges on how much influence they will truly be allowed. As pointed out, many remain sceptical about the extent of devolved autonomy that actually exists, but there were few signs of ambivalence in our study in respect of the desire to achieve it. This contrasts with previous studies which placed emphasis on the continued strong identification of clinicians with their profession rather than the organisation within which they work (Pollitt, Harrison et al. 1991);(Hoque 2004). There were, of course, still examples of the latter, but they were less in evidence in the lead trusts which had pushed ahead with the service line management concept. In these latter instances the allure of spending a proportion of retained surpluses locally, and the exemplar of divisions and directorates which had invested in new ventures, brought-in new clinical teams and initiated new services, were powerful attractors (Plsek and Kilo 1999).

The calibre of directors appointed to trust boards and the clearer emphasis on management – underpinned with guidelines about how it can be done - in the NHS suggests that the current reforms are not a mere repeat of Griffiths and similar initiatives. Thus one proposition to be tested in our future work is that a number of significant changes are now beginning to occur even though these may not be uniform across the trusts. Already we have found directors and senior clinicians who have responded enthusiastically – albeit but with some caution and even scepticism. Individual actors – including chairs of PCTs and hospital trusts are often critical of particular strands of the reforms but few claimed to be able to offer comprehensive alternatives to the overall pattern. To this extent they seem to be endorsing the direction of travel. Quality of service, a focus on improving the patient experience, allied with accountability for financial probity and the efficient utilization of resources, overseen by regulatory authorities - was a frame which seemed hard for these practitioners (including both senior managers as well as senior clinicians) to contest.

The behavioural responses recorded so far are interesting. The pursuit of entrepreneurial opportunities cover a spectrum – some chief executives and medical directors seem keen to push the boundaries and they pursue mergers and take-overs and new market opportunities with relish. Making service line management work to the full within trusts was said to require considerable ‘clinical engagement’, meaning that senior consultants would need to assume responsibility for the financial viability of their business units as well as the operational efficiency and clinical quality dimensions. Moreover, despite the many academic research reports in the 1990s reporting the lack of commitment by doctors to managerial roles (for example: (Weightman 1996) (Dopson 1996)), we found a number of senior consultants who were in fact eager to shoulder directorate lead roles in order - as they put it - to wield much greater influence, beyond individual patients to whole patient groups through the redesign of services and the allocation of resources.

Indeed, as we reported above, the more pressing issue appeared to be the reluctance of senior managers to let go. In their single case study of a middle range trust, Hoque et al found little desire for autonomy either from the trust senior managers or from the consultants, indeed they state ‘there was no desire for autonomy’ (p373). This was not the case in the Foundation trusts we researched. The chief executives and the Chairs did very much want autonomy for their trusts – not least because they wanted to escape the clawing back of surpluses by the SHAs – and likewise, the medical directors and clinical directors very much wanted autonomy for their departments and divisions in order to shape them in the way they desired. While these may not still be widespread trends across all kinds of trusts they are potentially very significant developments given the long history of thwarted ambition on these very fronts in the past. To this extent at least, the plethora of governance arrangements – including institutions, mechanisms, cultural expectations, skill sets, carefully selected post-holders and governance pro-forma (exemplar agendas, information requirements and designated sources of information, annual meeting cycles guidance etc) backed up with a capable and powerful regulatory bodies – may now be showing signs of impact. Once such a bridgehead is established, demonstrated and rewarded other parts of the system may be pulled along behind to a degree not so far experienced previously.

Alongside the lead cases, we also found many common patterns between the different case study trusts. The sources of the isomorphism were not hard to discern. First, there was the necessity to satisfy the regulatory bodies, thus trusts paid close attention to their published standards and their pro-forma toolkits. Second, in order to handle the detail, trusts commonly hired management consultants to advise and these bodies carried similar models and ways of operating from trust to trust. Third, the governance reforms have created a number of market-imitating conditions which tend to prompt like-minded behaviour between the trusts.

This tentative proposition of more change this time around needs of course to be set alongside the grounds for caution. This is no ordinary market, prices are fixed, trusts can undertake more (or less) activity and they can increase or decrease quality (subject to regulatory constraints and to league table consequences) but they cannot adjust the price; nor can commissioners (purchasers) cannot negotiate lower prices. Further, as noted, the command and control mode of central governance has by no means been rescinded. Likewise, the Department of Health’s annual ‘Operating Framework’ stipulates the priorities of central government demands from the NHS.

These forces are not necessarily inimical to the lead case examples we cited above. Indeed, if the demonstration case could be placed on a secure footing, these institutional mechanisms could be used to drive the model through the system. The intent to curb and check producer dominance and to drive innovation and efficiency has been pursued in numerous ways which may reinforce each other: the use of market and quasi-market mechanisms; new modes of accountability to users through user involvement and governing bodies; targets, auditing, performance measures and league tables; direct regulation by the state; the provision of well-regarded management tools; and so on. Thus, in total, ‘governance’ in the NHS represents an array of devices which draw freely on market, hierarchy and network principles.

While some analysts might cast these actors as 'self-disciplining subjects' (for example, Rose and Miller 1992; (Miller 1993), the effect is the same. New individual subjectivities are linked to new forms of knowledge and power. Thus, while the array of governance arrangements could be interpreted as serving to constitute subjects in new ways the result would underpin our central proposition to be tested – namely that multiple elements are falling into place which offer a set of imperatives and attractors which together form a powerful combination of forces which may allow this time around governing at a distance.

Such governing 'from afar' is not without its tensions. The empowered chief executives do not merely pursue approved goals; they also tend to become obdurate defenders of their institutions which can make reconfiguration of wider health economies more difficult. Likewise, the enthusiastic medical director or clinical director may be perceived as an obstacle by trust boards. But these tensions are all part of the system in so far as a departure is made from a simple command and control mode of governance. Governance will not get easier; it may become on balance more productive and innovative.

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