CORPORATE GOVERNANCE IN THE NHS: AN ASSESSMENT OF BOARDROOM PRACTICE IN ENGLISH DISTRICT HEALTH AUTHORITIES

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SUMMARY

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Corporate Governance - which is concerned with the management and direction of organizations at the very highest level - has grown in importance in the private sector, from where the concept largely derives, as a result mainly of malpractice. As a consequence, interest in the topic has grown steadily, largely on the part of Governments, regulators and academics. Managerial reforms of the NHS introduced refashioned District Health Authorities (DHAs) which mimic the role and structure of the Company board. The research reported in this thesis is an assessment of corporate governance in post reform English DHAs.

The research examines the characteristics of directors, the extent to which corporate governance can be empirically demonstrated, the extent to which it is consistent with the **Working for Patients** reforms, and, the consequences of such changes for the development of directors and of DHAs. The research also considers the relevance of the findings to other parts of the NHS and public sector.

The work draws upon the conceptual framework established by Tricker (1984; also Hilmer & Tricker 1991) with detailed survey and case study findings concerned with issues of direction, executive management, supervision and accountability. The findings from this new research make an important contribution to the policy debate and to the literature(s) concerned.

Key phrases: public sector management; corporate governance; NHS management; district health authorities.

This thesis is dedicated
to the memory of my father

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Introduction

1.1 Background

Since its inception in 1948 the NHS has always had some form of local organisational/managerial presence which, since 1982, have been known as District Health Authorities (DHSS, 1979). Prior to the creation of District Health Authorities much dissatisfaction was expressed with regard to the effectiveness of their predecessor bodies and, in particular, with the performance of their lay members. These problems were addressed in the *Working for Patients* reforms (CM 555, 1989) which created the revised, smaller and more 'business like' District Health Authorities familiar throughout England and Wales in the early 1990s. Fundamentally, this research is concerned with exploring the exercise of corporate governance within these post-reform District Health Authorities.

1.2 The Context

Reform throughout, and the contraction of, the public sector were major policy goals of the Conservative administration throughout much of the 1980s and 1990s. Hood (1991) highlights seven key elements:

* hands on professional management
* explicit standards and measures of performance
* greater emphasis on output controls
* shift to disaggregation of units
* shift to greater competition
* stress on private sector styles of management practice, and,
* stress on greater discipline and parsimony in resource use.

These themes are easily discerned in the series of initiatives to which the NHS was subject throughout the 1980s and early 1990s. Initial measures were directed to making the then system more efficient e.g. Rayner Scrutinies in 1982 and the introduction of performance indicators in 1983. These eventually gave way to a qualitatively quite different set of strategies which sought much more profound change:

* the introduction of general management (DHSS, 1983) as the means of changing the organisation and management of the service
* the community care initiatives (DHSS, 1986; DHSS, 1989) designed to change fundamentally the pattern of service delivery
* the nationwide health targets (Cm 1523, 1991) which promulgated explicit outcomes, and,
* quality (CM 555, 1989) and Charter initiatives (DHSS, 1991) which reinforce a customer-centred orientation.

Arguably, however, of these substantive strategies, the most important and the most radical was the *Working for*

Patients (CM 555, 1989) reforms. These were published first as a White Paper and subsequently brought to law as the NHS & Community Care Act 1990.

The *Working for Patients* reforms introduced a revised financial framework based on capitation funding, separate roles for "purchaser" and "providers" within a newly established internal market, and, allowed for the creation of NHS Trusts and GP Fund Holding (GPFH) practices. Of particular interest, however, are those aspects of the reforms which sought "better management" and which included the following specific proposals:

* the creation of a Policy Board and a Management Executive nationally
* new roles for NHS Authorities
* new membership of NHS Authorities, and,
* devolution of decision making.

(CM 555, 1989)

This research will be specifically concerned with the changes within English District Health Authorities. English, because the statutory framework and cultural diversity prevent meaningful national comparison, and District Health Authorities, because of their functional and political centrality relative to their immediate community. Although similar changes have taken place in Regional Health Authorities (RHA), NHS Trusts and Family Health Service Authorities (FHSA) these have been excluded from consideration on the basis that RHAs exercise a

'strategic' role and NHS Trusts are providers. FHSAs are purchasers, but are quite different from DHAs historically, culturally and organisationally. District Health Authorities are therefore quite distinct in their function as 'pure' purchasers and in terms of their relationship with the community at large as their natural constituency. Their role and function is concerned with:

* assessing the population's need for health care
* purchasing services for residents
* public health
* statutory responsibilities, and,
* managing Units which remain under their control.

The reforms, however, not only redefined the role of District Health Authorities in the above terms but also reduced them in size from sixteen members to a Non-Executive Chair, five Non-Executives members and five Executive members. The Chair is appointed by the Secretary of State and the Non-Executives by the RHA - on the basis of skill and experience only. Local Authorities therefore no longer have the right to nominate councillors to become members of District Health Authorities. Executive members include the Chief Executive and Director of Finance, who are appointed by the Non-Executives; the three remaining executives are appointed by the Chief Executive and the Non-Executive directors.

1.3 The Scope and Focus of the Research

It is no coincidence that the reformed District Health Authorities display a remarkable similarity to the private sector board. Indeed, as Fitzgerald & Pettigrew (1991, p1) observe:

> "The ideas draw on the experience of commercial, free market competition. In the commercial sector, the boards of companies act as the market managers."

Thus the size and structure of the reformed District Health Authorities together with the characteristics of the 'new' Non-Executives are all consistent with a more "business-like" approach. This is embodied in the modelling of these important public authorities upon the private sector institution of the company board.

Corporate Governance is the term used to describe "the purpose and methods of how we structure and control companies large and small" (Midgley, 1992 pvii). A more comprehensive view, however, holds that:

> "the governance role is not concerned with running the business of the company, per se, but with giving overall direction to the enterprise, with overseeing and controlling the executive actions of management and with satisfying legitimate expectations, for accountability and regulation by interests beyond the corporate boundaries. If management is about running business; governance is about seeing it is run properly. All companies need governing as well as managing"
>
> (Tricker, 1984 p6).

Given this perspective, it would seem that the model of the board - actively engaged in corporate governance - could bring to the direction of public service, a sense of clarity, control and responsibility which, from the perspective of the reformers, the NHS formerly lacked. If, as it seems, this was indeed the logic which underpinned these changes, it will be important to study progress, to both validate such developments and to inform future policy direction.

Recourse to the private sector via the overt privatization of services - or the 'privatization' of their culture and managerial rationale - has within it a whole tranche of assumptions which are themselves the subject of much political dispute and public controversy. Some commentators have argued that public services are different, even unique, and therefore the application of a private sector logic is wholly inappropriate (Stewart & Clarke, 1987). Others claim that the ideas and practices do not enjoy the superiority their advocates claim for them given, for example, the morally dubious or criminal behaviour at the centre of the Guinness, BCCI and Maxwell scandals. These broad strands raise serious questions about how appropriate private sector solutions are to public sector problems and the extent to which they are, in any event, intellectually and morally robust.

1.4 Critical Issues

The scale, rationale and process of reform in the NHS raises a number of critical issues. The first concerns the lack of evidence upon which the prescription is itself based (Pollitt, 1990) and the second that Government appears to be reluctant to engage in any systematic evaluation of the policy or its impact (Hunter, 1994). Whilst one can appreciate that evaluation is not value free:

> "evaluation is a political process, influenced by values, perceptions and priorities and not just a technical exercise"
>
> (Hunter & Williamson, 1989 p6)

there is clearly a compelling case to demonstrate the efficacy of a given policy choice.

In the case of the NHS a need to understand the reform of District Health Authorities is reinforced by the social significance of such organisations. In 1989, for example, there were 189 District Health Authorities in England and Wales, serving populations of between 89,000 - 860,000. The NHS is also economically important consuming some 6% of GDP in 1989, which represented £29bn in 1990. Clearly changes designed to improve the governance and performance of organisations of such social and economic significance must be evaluated.

The focus of such an evaluation is also critical with the choice lying, broadly, between formative and summative evaluation - see **Fig 1.1** Whilst this contrast appears to suggest either one or the other, any exploration of governance within District Health Authorities needs to reveal both micro and macro insights. Such a dual approach would thus inform both day to day practice and policy choice and development.

This research is therefore concerned with exploring and evaluating the existence and practise of corporate governance in English District Health Authorities. It will be concerned with understanding *how* District Health Authorities conduct themselves and their business - and the extent to which this is consistent with the practice of corporate governance - rather than with the success or failure of a particular District Health Authority function. The findings of the research will have organisational, economic and social implications for the practise and development of management in the NHS and beyond in the wider public sector.

1.5 Evaluating Existing Knowledge

Health Authorities/bodies and their members have been a source of rather specialised interest since their creation although the vast majority of this interest predates the *Working for Patients* reforms. Since these

Fig 1.1
Comparative Emphases in Formative and Summative Evaluation

	Formative Evaluation	Summative Evaluation
Primary Audience	Programme managers, managers and implementers.	Policy makers, interested publics, funders.
Primary emphasis in data collection	Clarification of goals, the nature of the programme process/ implementation, clarification of problems in implementation and in progress on outcomes. Micro level analysis of implementation and outcomes.	Documentation of implementation and outcomes. Macro level analysis of implementation and outcome.
Role of Programme Developers and Implementers	Collaborative.	Data providers.
Role of evaluator	Interactive.	Independent.
Typical methodology	Qualitative and quantitative with most emphasis upon the former.	Quantitative; sometimes enriched by qualitative.
Frequency of data collection	On-going monitoring.	Limited.
Primary reporting mechanisms	Discussion/meetings - informal interaction.	Formal report.
Reporting frequency	Frequent throughout.	On completion.
Emphasis in reporting	Relations among process elements - micro level relations among context and process; relations between process and outcome; implications for programme practises and specific changes in operations.	Macro-relations; context, process, outcomes. Implications for policy, administrative controls and management.
Requirements for credibility	Understanding of programme, rapport with developers/implementers/ advocacy/trust.	Scientific rigor, impartiality.

Source: Herman *et.al.* (1987) p26

reforms, the research effort has tended to focus on either the effectiveness with which District Health Authorities discharge particular responsibilities - predominantly purchasing - or, with the operation of District Health Authorities as Authorities/boards.

A number of figures dominated the pre-reform research landscape e.g. Ham, Haywood, Kinson, Ranade and Stewart (see Chapter 3) and, although most have retained some interest in Health Authority research, generally have tended to shift towards the issue of effective purchasing, rationing etc.. Not withstanding this, one of the most important *collective* contributions of this group has been to establish the subject as a legitimate field of interest and study. In addition, they have helped to map (and investigate) the critical dimensions including the attributes of members; their preparation and training; the structure and culture of Health Authorities, and the power structure in the NHS and the economic framework within which the NHS operates (Ham, 1986b).

Since the *Working for Patients* reforms - with some notable exceptions - there has been much less interest in Health Authorities as Authorities/boards. This is curious given the shift in District Health Authorities from that of a 'public Authority' to a 'corporate board'. A major exception to this was Pettigrew *et.al.* who undertook a

major study of post reform health bodies[1], a study so large as to (almost) silence the questions that might exist in this regard. The disappointment, however, was that much of it revisited earlier dimensions (all be it in a contemporary context) and only a part of the study looked at the new board structures, roles and patterns of work. Moreover, it also lacked any new insights or constructs appropriate to the study of such matters. Both in the serious study of these changes and in the manner of their investigation, therefore, there are important deficits in the literature.

Despite comparable changes taking place in Education, the Probation Service and the Police (and postulated in terms of Local Government) little of any substance exists in other parts of the public sector literature. This suggests not only gaps in the core literature but also in the wider public sector literature.

Turning to the private sector literature one is struck by the similarities rather than the more obvious differences between it and the core health care literature. The private sector literature has existed for some little time, is dominated by some key figures e.g. Demb & Neubauer, Lorsch and Tricker and, like the NHS, interested in boards and what they do (corporate governance), and, has been stimulated by controversy (e.g. Sutton, 1993).

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[1] *Authorities in the NHS* 1991-1993 - see Chapter 6

Tricker's model of corporate governance and its fields and dimensions offer an immensely helpful framework for the study of boards along with the role and contributions of Non-Executive directors. A significant gap in the corporate governance literature, however, is the absence of the application of such precepts to the study or management of not-for-profit/public sector organisations.

An evaluation of existing knowledge reinforces the need to undertake the proposed study on the basis of **important gaps in the literature.** In particular:

* the need for further/fuller study of the working of post reform District Health Authority boards;

* the need to bring innovation to the means of their study;

* the need to enhance - and perhaps generalise some findings to - the wider public sector, and,

* the need to develop and extend the corporate governance literature in respect of non private sector settings.

1.5 Research Questions.

The scope and focus of the proposed research, the critical issues that the reforms raise and the gaps in the core, public sector and corporate governance literature(s) all influenced and shaped the research questions. These are as follows:

1. To what extent do issues of **tenure, gender, age and ethnicity** influence the composition and orientation of District Health Authority boards ?

2. To what extent can behaviours consistent with Tricker's categories of:
   * **direction,**
   * **executive management,**
   * **supervision,** and,
   * **accountability**

   be identified and thus the existence of corporate governance demonstrated in District Health Authority boards ?

3. To what extent are such patterns consistent with:
   * the *Working for Patients* reforms ?
   * subsequent Codes of Conduct and Accountability ?
   * the recommendations of the Nolan Committee ?

4. What **implications** do the findings have **for the development of** District Health Authority **directors** ?

5. What **implications** do the findings have **for the further development of corporate governance** in the NHS and throughout the public sector ?

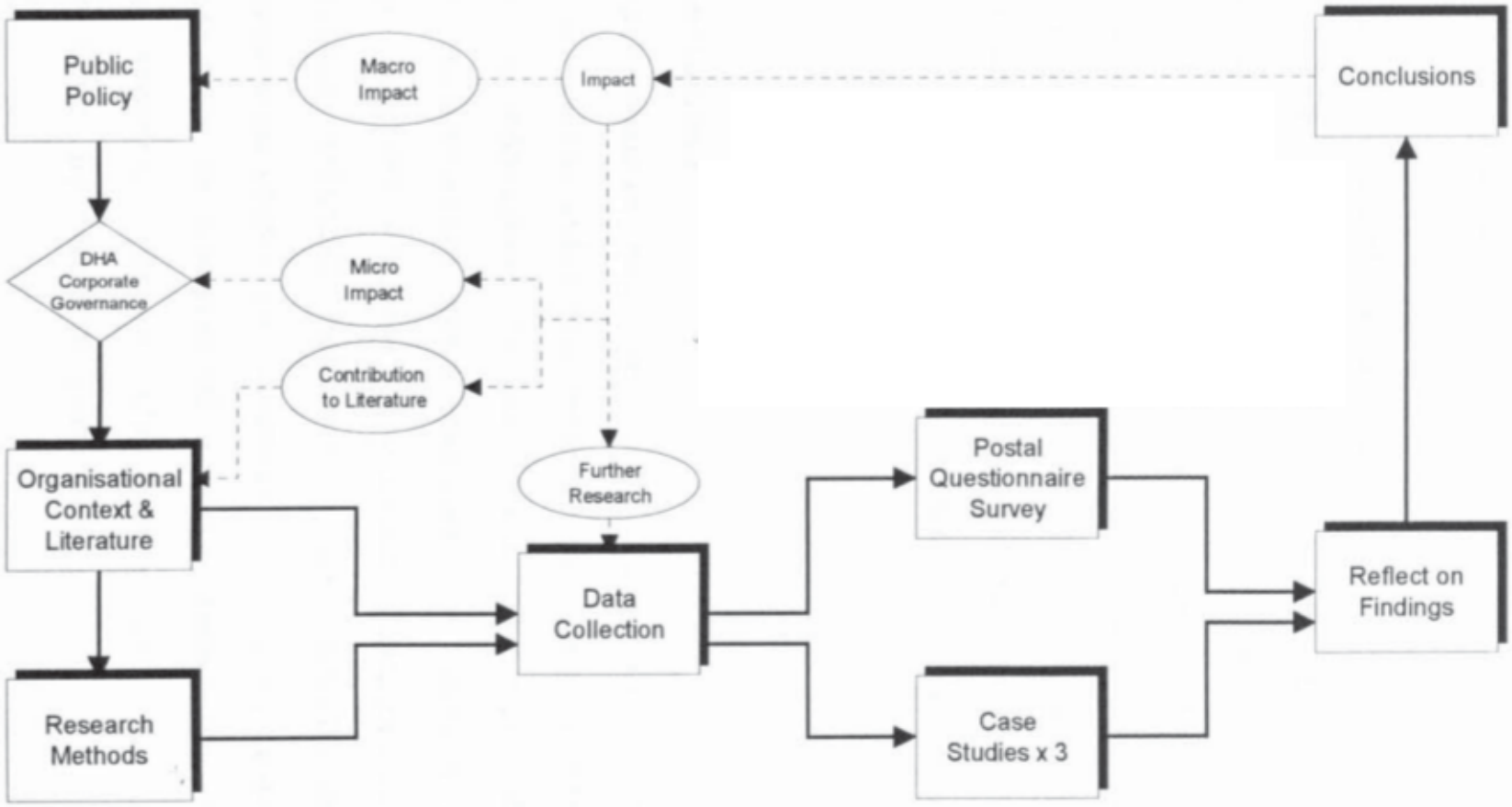
1.6 Structure of the Thesis

Fig 1.2 depicts the logic sequence of the study and the impact of the research findings. The findings will have an impact at a macro level on public policy, at a micro level on the practice of corporate governance in District Health Authorities, upon the NHS/public sector/corporate governance literature(s), and, in generating further research.

In terms of structure, following this introductory chapter the thesis is divided into five distinct parts. Part Two consists of five chapters. The focus of the Part is a consideration of the context for the research in terms of public sector/NHS reform (Chapter 2) and an exploration of the core Health Authority/member literature (Chapter 3), together with the issues and experience of governance in the NHS (Chapter 4). The private sector literature is also considered (Chapter 5) and common themes and key/ integrating issues identified (Chapter 6).

Part Three consists of two chapters: one concerned with issues of methodology and research design (Chapter 7) and one with a detailed consideration of the specific research methods employed in this study (Chapter 8). Part Four concentrates upon the findings from a postal questionnaire survey i.e. both a pilot study (Chapter 9) and the main survey. The findings from the main postal survey are reported using the four dimensions of Tricker's

Fig 1.2
Schematic Representation of Research Study and Impacts



model of corporate governance i.e. direction (Chapter 10), executive management (Chapter 11), supervision (Chapter 12) and accountability (Chapter 13). Chapter 14 considers the issue of board development.

Part Five consists of four chapters. Three chapters (Chapters 15, 16 and 17) report the findings from case studies Alpha, Beta and Omega respectively. Chapter 18 compares the case study and postal survey findings, and, compares the case studies one with another. Part Six consists of two chapters. One (Chapter 19) discusses the significance of the findings relative to the research questions, the other (Chapter 20) draws to a conclusion the research and the thesis.

1.7 Conclusions

This chapter has set out - in broad terms - the backdrop against which the research reported in this thesis was to be undertaken. In particular, the NHS and public sector literature(s) which defined the context and the private sector/corporate governance literature which established critical definitions and boundaries. This discourse also identified a number of critical issues, and, together with an overview of existing knowledge, revealed several important gaps in the literature - all of which helped shape the research questions.

It is anticipated that the results from this research will furnish new insights in terms of public policy and governance within the NHS and - to the extent that the study and the its methodology contribute to the debate about corporate governance in the NHS and non private sector settings - make a substantial and original contribution to the literature in *both* fields. Thus the research is necessary and of sufficient value and scope. Further it is organisationally necessary, theoretically significant and socially justified.

- Chapter 2 -

The Literature I: Continuity and Change in the NHS

2.1 Introduction.

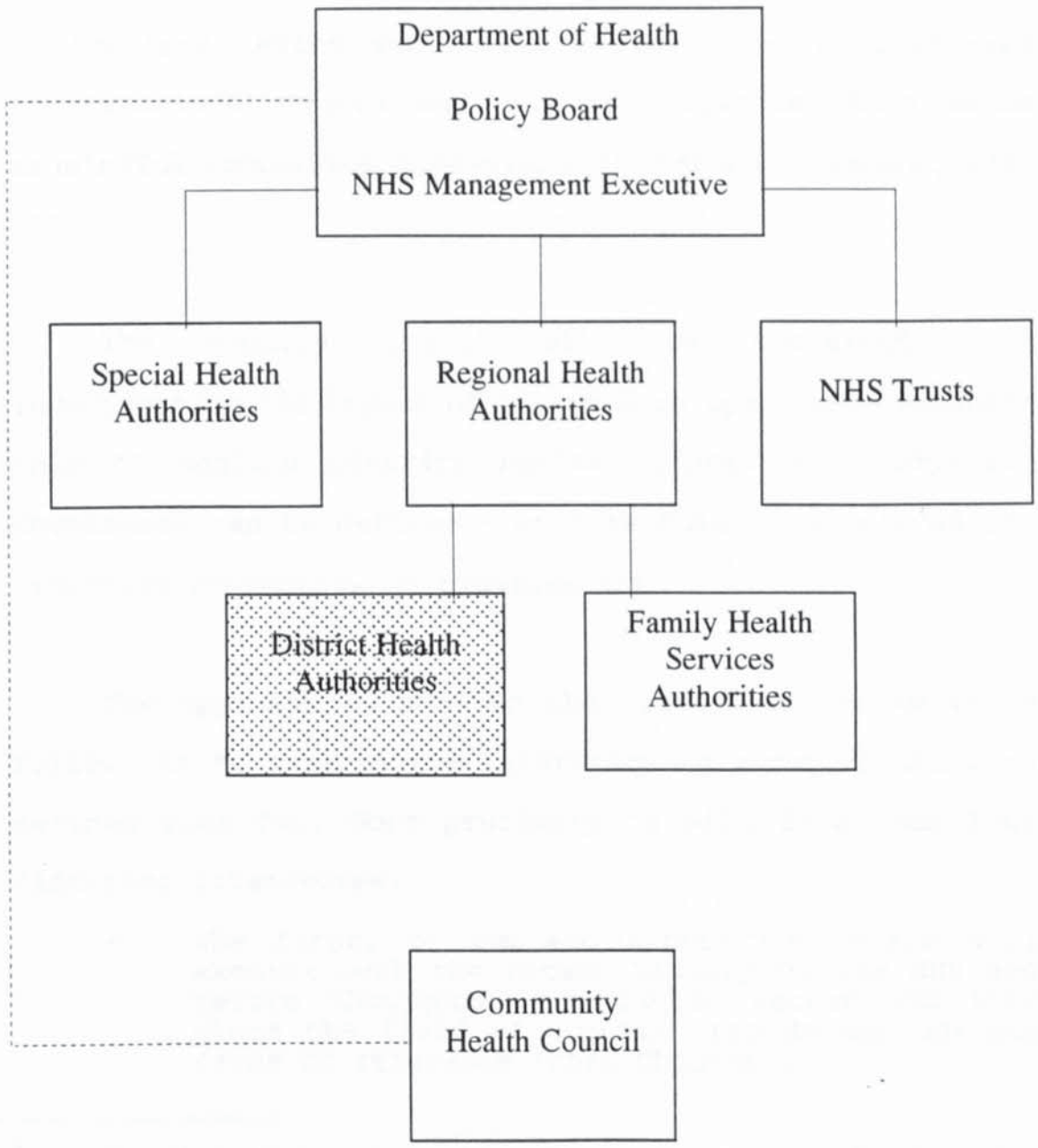
Since its inception the NHS has felt the need to have some form of 'local' executive presence, initially to administer and more recently to manage the service in respect of a given community. This principle has held true throughout the life of the NHS and remains so, even in a post reform health service. However, the reforms embodied in the NHS & Community Care Act 1990 fundamentally altered the nature of such entities and it is the purpose of this thesis to explore and evaluate the impact of (some) of these reforms upon those public bodies known as District Health Authorities.

It is important at this juncture to establish the scope and nature of the field of enquiry. Interest is focused upon District Health Authorities - see **Fig 2.1** - and therefore excludes Regional Health Authorities[1], Family

---

[1] Whilst RHAs may be considered to be part of the governance 'ecosystem', DHAs are distinct legally constituted corporate bodies. Whilst such freedom does not imply complete autonomy, DHAs are sufficiently sovereign to justify independent study of their governance practices.

Fig 2.1
Organization of the NHS in England



Health Service Authorities and NHS Trusts. While these latter entities are, or can be considered to be, health authorities or health bodies, they have a quite distinct composition, purpose and meaning both one to another, and collectively, relative to that of District Health Authorities[2]. Additionally, interest will concern only District Health Authorities in England since similar bodies in Scotland, Wales and Northern Ireland enjoy differing constitutional, legal and cultural legacies which makes meaningful comparison impossible (Hunter & Williamson, 1989 p7).

The enquiry itself will be concerned with investigating the impact of the reforms upon the governance role of English District Health Authorities. Corporate Governance can be defined - at this point - simply as the direction or control of organisations.

The approach adopted to the literature review which follows is to explore the literature relevant to the task defined thus far. More precisely it will draw upon four different literatures:

* the first, or context literature, which will examine both the recent history of the NHS and reform throughout the public sector and thus place the field of enquiry into an appropriate frame of reference (this Chapter);

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[2] Despite this exclusion the exploration of the core literature in Chapter 3 does contain references to studies which have considered all types of Health Authorities. This does not invalidate either their inclusion in the literature review or the exclusion of such bodies from this study.

* the second, or core literature, will be concerned with the Health Authority/Member literature and is central to the investigation (Chapter 3);

* the third will examine notable governance failures in the post reform NHS (Chapter 4), and finally,

* the private sector literature - which is central to the concept of corporate governance - will be examined (Chapter 5).

Collectively, the literature review will therefore:

* illuminate the circumstances both within and outwith the NHS which provoked reform:

* provide insights into the historical role, contribution and performance of Health Authority (HA) members;

* compare, briefly, the circumstances in Health and Local Authorities,

* explore the nature and significance of post reform organisational performance in the NHS, *vis-a-vis* corporate governance, and,

* draw upon the private sector experience for comparative and informative purposes

all of which will help to focus the enquiry and shape particular areas of investigation.

2.2 The Context.

It is only by reflecting upon what has gone before that we are able to understand the present, for the reality of to-days health service owes much to the recent past - particularly that period subsequently described as the 'Thatcher years' - and to its policy legacy. It is

convenient therefore to consider the context of this study as the period dating from 1979 to the present time.

2.2.1 Political Change. The period since 1979 has witnessed a number of significant political changes. Perhaps one of the earliest and certainly one of the most important was to be the **collapse of confidence.** This was born out of a decline in the optimism usually pertaining within and towards the NHS.It has been argued that a series of major incidents, dating from the salmonella poisoning incident at Stanley Royd Hospital in 1984, seriously damaged public confidence (Webster 1991, p168). This sense of misgiving was subsequently reinforced by a variety of specific concerns about e.g. communicable disease (AIDS and meningitis), nutrition (additives and class/regional dietary patterns), food safety (eggs, soft cheeses and BSE), water purity (Legionella) etc. Doubts mounted about the ability of the NHS to provide effective services and about the Government's commitment to social medicine. Much as confidence in the judicial system was later to dissipate so it was with health in the 1980s and in both instances the institution in question was widely perceived to be 'unsafe'.

Equally important and a concurrent issue was the **crisis of expenditure.** A significant feature of the period was the drive to curtail public expenditure generally and to contain spending within the NHS. Despite the fact that

UK expenditure on health increased in cash terms, the effect of this was largely diminished by inflation. Although cash spending had clearly increased and efficiency savings had been found, these were not equal to the requirement to address the effects of an ageing population, demographic change or the requirement for technological investment (DHSS, 1976). This together with mounting demands and expectations soon exposed an over stretched organisation and added to the doubts and misgivings described above.

Despite this gloomy picture, the Government frequently pointed to increased numbers of clinical staff and heightened levels of activity. Whilst this *was* the case, some increases in manpower were negated by reduced hours (nurses) and others by contract changes (junior doctors). The paradox of heightened activity appeared to flow from an admixture of genuine efficiency gains, improved management and revised clinical practice. Although the period was a troubled one it reached crisis point on more than one occasion, to the accompaniment of a succession of Secretaries of State. Finally,

> "The death of David Barber, the Birmingham baby, whose hole-in-the-heart operation was carried out only after five postponements, court cases, and much publicity, set off a wave of public outrage."
>
> (Webster, 1991 p176)

This incident was also to provoke an immediate review of the NHS - under the personal direction of the then premier Margaret Thatcher.

2.2.2 Institutional Change. These events were the backdrop against which wider institutional change was taking place throughout both the public sector as a whole and within the NHS itself. Turning first to **institutional change throughout the public sector** the most significant event was to be the Financial Management Initiative (FMI) and its consequences. The FMI was first published in 1983 (Cmnd, 9058) and was to cover all departments of State. Put at its simplest it can be thought of as an approach to strategic management "which involves assumptions about definition, survival, choice, performance and comparisons, clarity, resource and organisation" (Likierman 1985, p13). Its three basic principles were designed to:

> "Promote in each department an organisation and a system in which managers at all levels have:
>
> (a) a clear view of their objectives, and means to assess and, wherever possible, measure outputs or performance in relation to those objectives
>
> (b) well-defined responsibility for making the best use of their resources, including a critical scrutiny of output and value for money; and
>
> (c) the information (including particularly about costs), which training and the access to expert advice that they need to exercise their responsibilities effectively."
>
> (Cmnd 8616, 1982)

These principles were reviewed and extended in 1986 and devolved budgetary control added. Grocott (1989, p122) describes notions of cost centres being "transplanted" into Whitehall, a view supported by others who suggest these measures were concerned with "cost control" (Flynn 1990, p17). In 1988 - following experiments with grading and performance indicators - the Efficiency Unit published *Improving Management in Government: The Next Steps*, (Efficiency Unit, 1988) which introduced the separation of the management and policy functions through the development of "agencies" headed by a Chief Executive. Although these measures were focused upon the Civil Service they became a framework or mindset within which much of the public sector was to be accommodated.

Turning now to **institutional change** within the NHS it is necessary to cast one's mind back to 1982 and the implementation of the *Patients First* (DHSS, 1979) proposals for change. These represented 'unfinished business' in the sense of following through issues raised by the Royal Commission on the National Health Service (Cmnd 7615). The Royal Commission had been critical "saying there were too many tiers, too many administrators of all disciplines, a failure to make swift decisions and a consequent waste of money" (Levitt & Wall, 1992, p28). The *Patients First* proposals responded to these points by:

* abolishing Area Health Authorities and creating District Health Authorities

* shifting the focus of management from a functional to a unit/hospital team basis

* moving decision making nearer to the patient, and,

* revising and simplifying the planning system.

These measures were introduced in a Health Notice (DHSS, 1980) and were seen to be the means of rectifying the profound disquiet with the earlier, largely structural, reorganisation of 1974. Importantly, it also introduced the notion of the 'natural community' i.e. an identifiable centre of population and health infrastructure predicated upon the District General Hospital and the provision of comprehensive local services.

Although these changes worked well, their implementation was beset by financial pressures throughout the Service and coincided with the introduction of Compulsory Competitive Tendering and financial and manpower cuts. These forces and the mounting conviction that the calibre and performance of NHS management was less than perfect led the then Secretary of State, Norman Fowler, to invite the prominent businessman Roy Griffiths "to review current initiatives to improve the efficiency of the health service in England and to advise on the management action needed to secure the best value for money and the best

possible services for patients" (Fowler, 1983). The *NHS Management Inquiry* (DHSS 1983) - more popularly known as the Griffiths Report - was published in October 1983 and its principal recommendations concerned:

* D.H.S.S. - to create a NHS Supervisory Board and a NHS Management Board which was to establish General Management at national level

* Health Authority Chairmen - to promote and extend the review process, "identify" General Managers, establish General Management structures, "clarify" the roles of chief officers and review and reduce functional management

* Personnel Function - to be given greater prominence and priority together with issues of remuneration, appraisal, incentives and training; employment procedures and manpower were also to be subject to review

* Property Function - to be given greater prominence and priority; procedures were also to be streamlined

* Consultation - to be streamlined

* Patients and the Community - the report exhorted the Service to seek out and respond to the views of the consumer/community and to use these data in shaping policy and monitoring performance; the dialogue was also seen as a means of promoting realism.

These then were to be the means of addressing the team's concerns about inadequate management accountability, poor implementation, a lack of concern with performance and for the views of consumers.

Implementation of General Management went ahead in the face of some resistance from the professions and also some misgivings by Health Authority members who feared their role would be eclipsed (Levitt & Wall 1991, p33). These forces were finally quelled, or simply subsided, and the product of an enhanced management profile and reinvigorated sense of purpose were soon evident throughout the Service. A number of studies sought to evaluate this phenomena and were either cautiously optimistic (Stewart, 1987; Harrison *et.al.*, 1989) or largely unpersuaded (Harrison & Nutley 1993). In either event, as Pollitt *et.al.* (1991, p77) subsequently commented "there is a sense in which managerialism on the Griffiths model is founded upon distrust", a distrust that was soon to reemerge under conditions of financial crisis and public scandal. As noted above, this very combination spawned a review of the NHS under the direction of the then Prime Minister. In the fullness of time, the *Working for Patients* White Paper (CM 555, 1989) was published and its radical agenda brought to legislation on the 29th June as the National Health Service and Community Care Act 1990. Although the impact of this legislation upon Health Authorities will be considered in greater detail below, it is convenient here to take an overview of the reforms. The principal changes introduced:

* a revised system of funding hospital services which required a move from the system of Resource Allocation Working Party (RAWP) allocations to a system of capitation funding

* the separation of the commissioning function of Authorities from the provision of service by hospital and community Units i.e. the purchaser/provider split

* the creation of an internal market[3]

* provision to establish self governing NHS Hospital Trusts

* provision to establish GP practice budgets i.e. Fund Holding Practices, and,

* changes to Regional, District and Family Health Services Authority management bodies, together with the creation of a central Policy Board (to provide strategic direction) and the NHS Management Executive (to manage the Service Nationally).

These reforms - at least at the time of writing - represent the ultimate expression of institutional change. Further change is, however, afoot, with the Health Authorities Bill currently making its way through the legislative process in Parliament. This envisages further, largely institutional, change to:

* create a clear identity for the NHS Management Executive (NHSME), within the Department of Health, as the headquarters of the NHS;

* abolish the 14 statutory RHAs, reorganising the NHSME to include eight regional offices, each headed by a Regional Director, to replace both the RHAs and the existing NHSME Outposts;

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[3] This is a concept based upon the work of an American, Alain Enthoven and set out in the now legendary monograph, *Reflections on the Management of the National Health Service* (1985). This established the case for the internal market, the value of incentives and the efficiency gains to flow from such an approach.

* appoint non-executive director members of the NHS Policy Board to cover each of the eight regions, providing a link between Ministers, and local DHA, FHSA and Trust Chairmen, and,

* enable District Health Authorities and Family Health Service Authorities to merge[4] to create stronger local purchasers; such mergers will be actively encouraged.

(NHSME, 1993a)

2.2.3 Organisational Change. An essential accompaniment to the above process was the organisational change which took place 'around' or as a direct consequence of institutional change. This can be thought of in two ways. The first as almost a 'stream of consciousness' in the sense that initiative followed upon initiative throughout the 1980s. The second as a variety of linked initiatives concerned with the themes of efficiency, performance and accountability.

A closer examination of this latter perspective suggests that the Rayner scrutinies (1982), the introduction of performance indicators (1983) and their subsequent refinement (1985) were the embodiment of a concern with the efficient consumption of resources and the provision of public service. In a similar fashion the introduction of District Reviews (1983), Unit Reviews (1984) and Ministerial Reviews (1985) signalled a

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[4] Many DHAs and FHSAs are currently working together very closely, in effect 'merging' on an informal basis; these are frequently referred to as Health "Commissions".

systematic interest in and concern with organisational performance. Both institutional and organisational change clearly overlap to some degree in time and substance and therefore represent a somewhat artificial distinction, but which clearly have resonances of the crisis of expenditure and the focus upon accountability, the embodiment of which was the introduction of General Management.

2.2.4 Management Change. The final contextual dimension is that of managerial change. This term is used to denote those measures designed to reinforce individual behaviour or to redefine or regulate particular relationships. Initiatives in this category include the greater strength and clarity of purpose required of managerial roles, born of FMI and explicit in the NHS in the new General Management elite. This was expressed in the clear objectives and heightened expectations attached to new roles and contracts; enforced through the Individual Performance Review (IPR) appraisal system and the associated Performance Related Pay (PRP) incentive scheme. From meta ideology to individual behaviour in the field the circle was complete.

2.3 Conclusions

The analysis thus far has proposed a schema which depicts change at the institutional, organisational and managerial level against a wider public sector and

ideological backdrop, but, **what does all this mean ?** On one level this can be understood in the following terms,

> "Faced with the tension between expansionary pressures within and without the health service, and macro-economic pressures to control expenditure, the government of this country has tended to respond in two ways. The first is the search for increased efficiency, often associated with attempts to shift the balance of power within the NHS away from the professions, towards the managers, and the second is to change the values upon which public provision is based from welfare to markets"
>
> (Barrett & McMahon 1990, p257)

This is exemplified in the introduction of General Management and later the *Working for Patients* reforms. Important as such a view undoubtedly is, it provides only a partial understanding. Whilst the how and why of environmental change are explained at the macro level, micro level behaviour and culture are largely ignored. An early examination of the values at work suggest the initial adoption of the economy, efficiency and effectiveness credo which was subsequently augmented by excellence and enterprise (Gunn 1989, p10). As these were internalised and generalised throughout the public sector/NHS so the notion of a new "doctrine" could be discerned:

* 'hands on' professional management
* explicit standards and measures of performance
* greater emphasis upon output controls
* shift to disaggregation of units in the public sector

* shift to greater competition in the public sector
* stress on private-sector styles of management, and,
* stress on greater discipline and parsimony in resources use.

(Hood 1991, p4)

This suggests more than the simple replication of behaviour patterns but rather a paradigm shift on an unprecedented scale. Indeed it was to be this doctrine that eventually produced a new and substantive culture. Whilst this new culture is not *entirely* a creature of the private sector, there are sufficient similarities for it to be represented as such, and, as a consequence, for the political debate to posit it at the opposite end of a continuum i.e. past V present, good V bad etc.. This polemic is best characterised by Pollitt (1990) in the contrast he draws between the values of the private and public sector - see **Fig 2.2.**

Fig 2.2
Value Differences between a 'Generic' Private Sector Model and a Public Sector Orientation

Private Sector	Public Sector
1. Individual choice in the market.	1. Collective choice in the polity.
2. Demand and price.	2. Need for resources.
3. Closure for private action.	3. Openness for action.
4. The equity of the market.	4. The equity of need.
5. The search for market satisfaction.	5. The search for justice.
6. Customer sovereignty.	6. Citizenship.
7. Competition as the instrument of the market.	7. Collective action as the instrument of the polity.
8. 'Exit' as the stimulus.	8. Voice as the condition.

Source: Pollitt, 1990

To a large extent those changes built a momentum of their own. The professions had been largely subdued, there was little academic analysis of note and, although macro political resistance was evident, a large Government majority and an Opposition in some disarray resulted in a continuing diet of reform. One notable dissenting view was the seminal work of Stewart & Clarke (1987) who argued the existence of a distinctive "public sector orientation", but to little avail. A Conservative victory in the 1992 general election modified the tone but not the relentless pattern

of change. Interestingly, there was no coherent or effective managerial focus or debate throughout much of this period. This may have been as a result of the constraints public sector managers face in instituting change (Ring & Perry 1985), or simply the increasingly powerful self interest of emergent *managerial* elites.

Towards the end of the 1980s sufficient evidence and experience had been accrued to move towards the development of, first, a descriptive and then an explanatory theory. A major contributor was Pollitt (1990, p1) who coined the term "managerialism" to describe "a set of beliefs and practices, at the core of which burns the seldom tested assumption that better management will prove an effective solvent for a wide range of economic and social ills". This study crossed national and institutional boundaries and in a UK setting explored developments in the civil service, health and education. This latter analysis, particularly, reveals a cycle of innovation, imitation and convergence in the policy framework for what previously had been three very different organisations.

Clearly, managing under these conditions was not without difficulty, particularly in the period of the (relatively slow) transition from the 'old' to the 'new' paradigm. This created risks and uncertainties for practitioners who coped by mapping new "domains" (Harrow & Willcocks 1990) and by establishing, incrementally, a

"negotiated order" (Barrett & McMahon 1990). Gradually, however, theory and practice fused. As this movement became a 'body of knowledge' so its intellectual and ideological strengths and weaknesses were exposed (Hood 1991) as were internal inconsistencies. As Hoggett (1991) observed:

> "The new paradigm comprises a paradoxical development through which radical forms of operational decentralization become combined with further centralization of strategic command".

This analysis of the contemporary context of the NHS reveals a massive change in the public sector environment, coupled with an equally profound shift in values. Both combine to form a "new public management" (Hood & Jackson 1991, p178) characterised by a shift,

* from policy to management
* from aggregation to disaggregation
* from planning and public service welfarism to cost cutting and labour discipline
* from process to output, and,
* a divorce of provision from production.

(Aucoin 1962)

These then were the conditions in which governance was to be enacted.

- Chapter 3 -

The Literature II:
The Role and Performance of the Health Authority Member

3.1 The Nature and Role of Health Authorities.

An obvious starting point must be to explore and define the nature and role of Health Authorities - and inevitably the activities of members - both of which have been subject to significant change over time.

An early definition saw the role of Scottish Hospital Boards as being "to provide and administer on behalf of the Secretary of State that part of the hospital and specialist services which has been assigned to them under regulations or directions made by him" and which also included planning, management and supervision together with "the general oversight of the patients care" (Farquharson-Lang, 1966 p15). This is a useful historical note since Health Authorities, as the term is now understood, were not introduced until the reorganisation of the NHS in 1974.

What was soon to become evident was the remarkable durability of the above view. Indeed, studies which underpinned the Royal Commission saw Authority members being concerned with monitoring management, planning, dealing with "specific major issues" and "acting as a

catalyst of public opinion and then arbitrating between the professionals in the service and public demand" - "more a policy making than a managerial role" (Kogan *et.al.*, 1978 p15). Despite this, he viewed the member contribution in the following terms, "their impact upon the service was felt to be slim" (ibid, p75). Hunter (1981, p158) viewed Scottish Health Boards "primarily as management bodies" given their responsibility for "major policy, strategic planning decisions, the broad allocation of resources and matters of substantial interest to the community" He too, however, was also sceptical about their impact seeing "a 'mismatch' between prescribed practice and actual practice" (ibid, p181).

A fuller description of the role and contribution of the Health Authority member is given by Haywood (1983, p23) who describes their role in "decisions"[1] and their "involvement"[2] in other than formal meetings, although he too is rather gloomy in his assessment:

> "The general feeling in the NHS is that members, by and large have had little impact on the conduct of health authority affairs."
>
> (Haywood & Alaszewski, 1980 p89)

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[1] These are decisions concerned with "legitimation", "endorsement", "choice", "information for the public record" and "the receipt of reports".

[2] This range of duties includes visiting panels, sub committees, representing the DHA on internal bodies and involvement in special interest groups.

This was a theme to which he was later to return when, in the aftermath of the Griffiths report, he took the view that:

> "Members must either adapt to the new emphasis on expectations and performance or accept that they are simply the 'dignified' element of the NHS constitution, the public facade of the private machine."
>
> (Haywood & Ranade, 1985 p112)

The mid 1980s, however, began to witness a dissatisfaction with such an assessment. A view which was itself influenced by the new public management and therefore increasingly saw Health Authority/member effectiveness in 'management' terms. Indeed it was around this time that the term *governance* made its first appearance in the lexicon of the NHS:

> "The District Health Authority lies at the end of a governing line from the Secretary of State. . . a necessary institution which is responsible for specifying and promoting change by setting political aims, and seeing that these are pursued through strategic programmes. This is the work of governance."
>
> (Kinston, 1986 p25)

The above statement continues, "By contrast, executive work is concerned with developing and pursuing strategic and operational programmes", thus indicating clearly that governance is defined in both absolute and relative terms. Another study to reflect something of this new mood was the work of Rosemary Stewart, who, in the course of the

Templeton Series on General Management, identified the roles open to Health Authority members thus:

* "ensuring policies take account of public views
* mediating between management and other interests
* monitoring, and,
* specific action"

but added that "members have limited and intermittent contact with complex, continuing issues, so it is hard for them, whatever their calibre, to play some of these roles effectively" (Stewart, 1987b p5). Doubt could no longer remain. Despite reorganisation of the Service in 1974 and in 1982, and the introduction of General Management in 1984, it was becoming clear that as the professional management of the service was being exhorted to greater and greater efforts, so the lay membership of Health Authorities appeared further and further adrift. These forces combined and together with the *Working for Patients* reforms were to have dramatic consequences for the nature and role of Health Authorities.

It will be recalled from the earlier overview of the reforms in Chapter 2 that a major plank of the reforms was the separation of the purchaser and provider interests and the creation of an internal market, within which District Health Authorities would identify health needs and purchase services to meet those same needs. The separation of

purchaser and provider interests therefore allowed District Health Authorities to:

> "concentrate on ensuring that the health needs of the population for which they are responsible are met; that there are effective services for the prevention and control of disease and the promotion of health; that their population has access to a comprehensive range of high quality, value for money services".
>
> (CM 555, 1989 p14)

Subsequent guidance saw the principal focus of the District Health Authority as being concerned with:

* assessment of health need
* appraisal of service options
* specification of the chosen pattern of service provision
* choosing between providers and placing contracts
* monitoring
* controlling expenditure on contracts

but went on to add:

> "DHAs will at the same time retain responsibility for the finance and operational management of their directly managed units. Effective discharge of the purchasing role will require DHAs to ensure that they separate this activity from the managerial role they retain"
>
> (NHSME, 1989 p2)

It was soon evident that District Health Authorities would be required, simultaneously, to operate a trading relationship between 'equal' partners and sustain a managerial relationship between 'unequal' participants. This would produce both ambiguity and a highly complex managerial environment - one which would require leadership, policy direction, the accommodation of national policy to local circumstance and all within available resources (Ham *et.al.*, 1990 p19).

Perhaps the greatest change District Health Authorities were to face was the reduction in size from 16-19[3] members to 6 Non-Executive (including a Chair) and 5 Executive *members* (including a CEO and Director of Finance). This was on the basis that:

> "If health authorities are to discharge their new responsibilities in a business-like way, they need to be smaller and to bring together executive and non-executive members to provide a single focus for effective decision making"
>
> (CM 555, 1989 p65)

Although congruent with the overall pattern of reform, these changes also reflected the Government's own concern about the "long-standing lack of clarity about the role of

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[3] Immediately prior to the *Working for Patients* reforms DHAs had a membership which derived from appointments made by the Secretary of State and the Regional Health Authority, and reflected nominations from the University (in the case of a Teaching District), the Local Authority, the professions and voluntary interests.

health authorities" (ibid, p64). Under the reformed arrangements Health Authority Non-Executives were to be involved in:

* appointing the general manager and advising the chairman on the performance of the general manager
* working with the general manager to appoint the other executive directors
* advising the chairman on the salaries and conditions of employment of executive directors
* advising on top management structure, and,
* acting as the chairman's sounding board.

(Ham *et.al.*, 1990 p22)

It is no coincidence that this displays a remarkable similarity to the private sector equivalent of the Company board. Indeed, as Fitzgerald & Pettigrew (1991, p1) observe in regard to the reforms:

> "These ideas draw on the experience of commercial, free market competition. In the commercial sector, the boards of companies act as the market managers".

This exploration of terms reveals some continuity in both the role of Health Authorities and the impact of members in the policy making process. This remained so until the late 1980s when a mixture of environmental and ideological forces prompted a radical change of direction for all Health Authorities, but particularly so for

District Health Authorities. Over time Health Authorities have grown or shrunk in size and have been more, or less, representative or managerial in emphasis. The present view clearly favours small and managerial. So much so as to bear comparison with the private sector board and its task of governance.

3.2 The Individual Attributes of Members.

I now wish to turn to a consideration of the individual attributes of members. Perhaps because of concerns with their impact there has existed from the very outset an interest in the characteristics and qualities of members themselves. One of the earliest commentators saw this as fundamental to effectiveness in that the "nominations [of members] will ultimately stand or fall primarily on the capability of the individual" (Farquharson-Lang, 1966 p14). The importance of personal qualities clearly also exercised the thinking of the Royal Commission who observed in the face of members' "limited" impact:

> "This was not because of defects in member quality which varied enough to ensure that at least some of them were able people"
>
> (Kogan *et.al.*, 1978 p73)

Interest from this point onwards largely shifted from a suspicion that members were not equal to the task, to one

which felt some were more equal than others. This in turn produced a number of studies which, directly or indirectly, sought to isolate the 'key variables'. Some took an essentially trait approach:

> "...have an unbiased and critical approach to problem solving so that the right questions are asked when plans and policies are reviewed... possess common sense and good judgement... be able to provide leadership to officers without attempting to do the work of officers... be able to work well in a group so that Area Health Authorities can function effectively as corporate decision making bodies"
>
> (ACAHA, 1981 p6)

others extended this and developed "pen portraits" but from a more robust empirical base (Haywood, 1983 p9). This latter study examined age/gender mix, qualifications, experience and aspirations. Whilst concluding that members were largely middle class and middle aged they were also "disproportionately well educated, with relevant expertise, experienced and successful.... also strongly motivated and well disposed to the NHS" (ibid, p16). Haywood extended and developed this thinking in later work when he argued that such qualities, the members themselves and the dynamics of particular settings combine to produce:

* policy specialists
* policy strategists
* loyalists
* back benchers
* representatives
* mission/ideologues (Haywood & Ranade, 1985 p40).

An interest in exploring the relationship of impact and member qualities was a well established theme and further studies followed (Kinston, 1886; Ham, 1986a; Ham 1986b). In addition to personal characteristics, available time and remuneration were identified as important influences. Although Ham viewed members as occupying "a largely symbolic role, a token gesture to the need for some kind of public involvement in the NHS" he also took the view that although member influence was "limited", it did vary between Authorities and it "tended to increase" over time (Ham, 1986a p5). The argument for "strengthening" the member role which he presented was, however, given an added frisson by the implementation of General Management which was taking place at that time.

> "The general management function can give purpose to the Authority. It does not detract from their responsibility. It simply sharpens them up so they are getting a much better service, that the particular points which ought to be considered and put on the table are in fact there, well prepared, well documented and brought together ready for the decision of the Authority, as distinct from what looks like, from the agendas of some of the authorities, a continual part serial which is published every month."
>
> (Griffiths, 1984 p149)

The implementation of General Management and its immediate aftermath inevitably shifted the emphasis from the lay to the professional contribution to health management. The development of managerialism both explains this phenomena and gave impetus to the subsequent *Working for Patients* reforms. The implementation of these reforms at District

Health Authority level required a shift in emphasis and role of "members" to "non executive directors" (Ham *et.al.*, 1990 p24) and from "officers" to Executive directors, although this particular dimension of the changes received comparatively less attention. These changes required both parties to work together on an *equal* basis in a unitary board arena.

Perhaps the most comprehensive, certainly the most ambitious, study of Health Authorities and their members was the *Authorities in the NHS* project carried out under the overall direction of Pettigrew between 1991-93. This examined, as one of its research topics, the characteristics of (Non-Executive) directors and found - as Farquharson-Lang had done 25 years previously - that the recruitment, retention and motivation of "elite volunteers" was a critical issue (Pettigrew *et.al.*, 1991 p12). Subsequent work focused upon the selection and recruitment process which, in terms of the criteria, attracted the comment that they "do not appear to be radically different from those in the past.... they reflect a change of emphasis"[4] (Ashburner & Cairncross, 1991 p6). It is unsurprising therefore to find a consistent pattern of characteristics over time and thus "a high degree of continuity in composition" (Cairncross *et.al.*, 1991 p3).

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[4] Business skills and experience given a high priority.

This brief consideration of the attributes of members reveals a high degree of consistency in what might be described as their demographic profile. This has shifted slightly of late with the inclusion of more women and ethnic minority representation but still shows a bias toward white, middle class, middle aged well educated and experienced (business) men. They are regarded by almost all who have systematically studied them as 'good people' - except for those members described as manifestly "political" (Haywood & Ranade, 1985 p69) - and who demonstrate high levels of commitment towards, but a declining knowledge of, the NHS (Cairncross *et.al.*, 1991 p4). Perhaps the most persistent area of unease is that associated with their recruitment and appointment. This is an ill understood process. In the case of District Health Authorities, Chairs are appointed by the Secretary of State and Non-Executive directors by the RHA which creates the suspicion of patronage (Philips, 1991) together with ambiguous loyalties and arguably poor accountability (Regan & Stewart, 1982 p22). From time to time the view has been advanced that this could be overcome by submitting to the ballot box (ibid, p31). Whilst democratically impeccable the innumerable barriers have thus far remained proof against the remedy.

3.3 The Preparation and Training of Members.

Another recurring theme in the literature is the preparation and training of members. As in this case, a

topic frequently associated with their individual characteristics, on the basis that they offer an explanation and a remedy for variations in performance. One early study clearly identified the concern of members themselves with the "sophistication, variety and detail of the data" they were confronted with (Kogan *et.al.*, 1978 p76), an indication of their "limited" knowledge (ACAHA, 1981 p11). Such views stimulated intervention in the form of a *Training Programme for District Health Authority Members* (Haywood *et.al.*, 1981). The need for such approaches being regularly reinforced (e.g. Haywood & Ranade, 1985 p121) but in some instances with a measure of qualification:

> "The most difficult task in training members is not teaching them about the NHS and its policies but ensuring that they understand and can work within a well defined role."
>
> (Kinston, 1986 p33)

As this statement implies, knowledge by itself may not be sufficient. One study in particular examined in some detail "support services" for members (Ham & Haywood, 1985), arguing the case for a members' support post in each Authority, improved information and the provision of facilities etc.(ibid, p4). The value of training *and* support thereafter became the orthodoxy (NAHA, 1986; Ham, 1986a; Ham 1986b).

Whilst the size of Authorities has fluctuated over time and the emphasis given to 'representation' and management varied, the changes to flow from the *Working for Patients* reforms were dramatic, radical and far reaching. This was particularly so in terms of the demands made upon members and the consequences this had for the knowledge and skills they would require (Spry *et.al.*, 1989 p5; Ham *et. al.*, 1990 p30). Unsurprisingly, these themes and the importance of training feature prominently in the *Authorities in the NHS* project (CCSC, 1991 p4). This is given a particular piquancy since (all) members face "different and more complex tasks" (Ashburner & Cairncross, 1991 p41). The project offers the most thorough analysis of member learning needs thus far and in particular highlights critical "knowledge gaps". It would seem that the general management skills of "management, leadership, planning, local knowledge and personnel" are well represented, but, "marketing, legal, contracting and IT" were felt to be lacking (Ashburner & Cairncross, 1991 p34). Clearly much remains to be done if the recast membership of District Health Authorities are to achieve the levels of effectiveness that eluded their predecessors.

The discussion thus far has centred upon the impact of members in terms of their personal characteristics and the extent to which their knowledge and skills - and thus their performance - can be improved. This assumes, however, that the conditions in which such qualities can flourish exist.

A major influence and a potential constraint, is therefore, the organisational structure of District Health Authorities.

3.4 DHA Organisational Structure.

As noted previously, although the term health *authority* did not come into existence until 1974, they and their predecessor organisations show a consistent vulnerability to having their name, size and emphasis varied over time.[5] Looking 'behind' the detail of this history, one is struck by the consistency of the analysis which has argued that marginal structural change may remove barriers to heightened performance or, the more iconoclastic view, that has promoted profound change as the only viable course. Examining the first of these, some have suggested the need to 'structure' the non policy and decision making activities of members, to involve members in more detailed deliberations outwith the formal meetings of the Authority, or, the need to bring more order and focus to their public meetings (ACAHA, 1981 p9; Haywood *et. al.*, 1981 p35; Haywood, 1983 p35; NAHA, 1986 p16).

Whilst supporting these propositions, others have highlighted the importance of chairmanship in creating optimum conditions and in steering the Authority (Haywood,

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[5] For a full discussion of this topic see for example Chapter 1 in Levitt & Wall (1992).

1985 p65; Ham, 1986b p123; Ham *et.al.*, 1990 p20). Indeed "good, strong chairmanship and non autocratic leadership, sensitive to member opinion was commonly mentioned as a criteria of effectiveness" (Haywood & Ranade, 1985 p68). Although this is obviously so, there is infinite variety in the enactment of this role (Stewart, 1987a). The twelve most frequent activities of chairmen are to:

* monitor the DGM's work
* discuss with District Health Authority
* monitor patient care
* discuss with the RHA
* set DGM objectives
* advise what to present to District Health Authority
* advise when to present to District Health Authority
* advise how to present to District Health Authority
* advise on difficult problems
* advise on finance
* advise on RHA

(ibid, p6).

An alternative to marginal change - profound organisational change - is not a recent phenomena. As early as the mid 1960s an alternative to the dissatisfaction of the time was the case for a "chief executive" and "an analogy from industry .... a board of directors" (Farquharson-Lang, 1966 p93). This was not an isolated

view, and, with some variation, proposed on a regular basis in the literature (Watkin, 1980 p116; ACAHA, 1981 p17), from a Labour government (Day & Klein, 1983 p1813), by the Royal Commission (Cmnd 7615) and finally as a part of the most recent Conservative reform of the NHS. Not only have structures changed but so to have attitudes. In the recent past the 'gentlemen and players' attitudes, which characterised much of the public service accepted the amateurism of institutions such as Health Authorities. The contemporary mood, imbued by the enterprise of public management, has established a different agenda and higher expectations:

> "The new form of DHA .... should be in a position to exercise more influence upon managerial decisions. Hence effective leadership in the Authority will be even more important than before."
>
> (Stewart, 1989 p72)

Not withstanding this, dangers remain. If former members and officers are unable to accept and integrate their new role(s) as Non-Executive and Executive directors, improvement might not be secured. As so often in the past, the role of Chairman will be critical (Fitzgerald & Pettigrew, 1991 p28). Whilst this element of the core literature has sought to concern itself with structure, it is impossible to dissociate this from those who inhabit it and the product of their collective behaviour - culture. It is to this that we now turn.

3.5 Health Authority Organisational Culture.

An area of the core literature closely related to structure is that of organisational culture. Closely related in the sense that a given culture will tend toward given structural preferences and particular structures will have cultural consequences (Handy, 1979 & 1981). This latter view, particularly, is one to which we will return when considering the secondary literature in due course. A useful definition of culture describes it as:

> "the pattern of values, beliefs, norms and rituals which define the essential character of the company. Just as the social group may socialise its new members, so too will the organisation socialise its new recruits to accept the status and power distribution, language, reward and punishment system and its ideology and philosophy"
>
> (Hucznyski & Buchanan, 1991 p449)

or alternatively, it may be thought of as,

> "the integrated pattern of human behaviour that includes thought, speech, action and artifacts and depends on mans capacity for learning and transmitting knowledge to succeeding generations"
>
> (Deal & Kennedy, 1982 p4)

Although both definitions are correct, the former conveys rather more effectively the familiar resonances of the concept. The latter, however, pinpoints the critical importance of *transmission* in both creating and sustaining culture. This is especially significant in Health Authority

terms since it is the reported views of members, chairmen and officers that constitute much of the literature and is, therefore, the material upon which the following analysis is based.

One early and prophetic view, expressed by members themselves, was that they felt "remote" from management and that "only the chairman was well enough placed to make an impact on the decision making of officers" (Kogan *et.al.*, 1978 p73). The conflict within the trinity - of chairman, members and officers - and betrayed in this statement, stalks the literature and the history of Health Authorities. Whilst neither complacent, or reflecting a universal truth, many members felt at ease with their role "often rating their influence on policy more highly than did their DMT[6] (or chairman)" (Haywood & Ranade, 1985 p29). By comparison Chairs express greater clarity of purpose (Haywood, 1983 p29; Haywood & Ranade, 1985 p65) being described as "tribune" (spokesman for the community), "prefect" (agent of central government) or "patriarch" (head of DHA 'family'), (ibid, p72). All of these facets of the role reflect the diversity of the role of the Chair and therefore the greater possibility of an affinity with officers. Indeed one study suggested that some 25-35% of all chairman contacts was with their officers, and 2-20% with their members (Haywood, 1983 p32). This alliance is beneficial, in both practical and cultural terms, since:

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[6] DMT = District Management Team

> "through the use of language, officers and chairmen endeavoured to manage meaning .... creating a climate in which their definition of the authority's role predominated."
>
> (Ham, 1986b p125)

Although senior officers of necessity have had to ally themselves with their Chair, their view of members per se has been much less than positive (Kogan *et.al.*, 1978 p75), even "ambivalent" (Stewart, 1987b p6).

> "Officers attitudes towards members vary but a commonly recurring theme in these attitudes is that members are relatively unimportant actors in the health service arena. While this judgement reflects fairly the actual influence of members in most authorities, it tends to result in a self-fulfilling prophecy; this is that members exercise limited influence because officers believe that members are unimportant. In contrast, officers are influential actors both in their own judgement and that of members."
>
> (Ham, 1986a p19)

Perhaps because of these divisions much stress has been put upon "unity of purpose" (Haywood & Ranade, 1985 p30), the "corporate role" (Ham, 1986a p9) and more recently "corporatism" (Ham *et.al.*, 1990 p19). This is a view which has grown in importance as reform of the NHS has gathered momentum. However desirable such a view may have been in the past, officers and members (effectively) inhabited different worlds and any tension or discord carried with it an air of inevitability. Now of course Non-Executive and Executive directors *have* to inhabit a single world and share a common purpose in the setting of a unitary board.

This may be aided by greater homogeneity and smaller size, together with the management and composition of authorities (Ashburner & Cairncross, 1991 p38). The importance of establishing this new culture will be central to the success or otherwise of reform.

> "For a balanced board membership to work well, as in a Health Authority, the executives will have to be prepared to discuss, decide on and review norms of behaviour and test their appropriateness to the new environment. Without the correct balance, there is a danger that authorities will become locked in outmoded and inappropriate ways of doing business, which will make them less effective."
>
> (Fitzgerald & Pettigrew, 1991 p26)

It is clear from this brief exploration of culture that two or three sets of interests seek the dominant role and therefore the power this confers to assign culture. This, the final element of the core literature, is the matter to which we now turn.

3.6 Officer - Member Relations.

From the outset, issues concerning the distribution of power and the exercise of influence have featured prominently and consistently in the literature. Almost without exception these have been discussed in terms of officer member relations. In part this discussion has sought to distinguish between the 'proper' role of member and officer, in part to offer some explanation for the limited impact of members upon policy making.

Turning first to a consideration of the District Health Authority members formal role, this has, at each stage in its evolution, been specified in the rubric of officialdom (e.g. DHSS, 1981; DOH, 1990). This in turn has been reinforced by a variety of supporting guidance from the Department of Health, the publication of research material and the output of the National Association of Health Authorities and Trusts (NAHAT). Despite this, however, confusion (and disagreement) has prompted an almost continuous debate in an effort to secure the correct balance or alignment between member and officer.

One of the earliest manifestations of this ambiguity was expressed in the following terms:

> "senior officers have been regarded as having considerable administrative responsibilities and powers of decision although their management responsibilities and relationships with boards have never been precisely defined".
>
> (Farquharson-Lang, 1966 p19)

Farquharson-Lang proceeded to consider the "delegation of responsibilities to officers" (ibid, p20) and thus reinforced the conventional wisdom that members made policy and officers implemented it. This view was systematically represented in all but the most recent guidance and thus served to create widespread dissatisfaction with the

growing gap between the rhetoric and the reality.[7]

Turning now to the explanatory dimension of officer member relations one is confronted with a complex multiple reality. Part of this suggests - e.g. for reasons of member quality, preparation and training and the complexity of their task - that members can do little more than "rubber stamp" matters put before them.

> "They received, probably encouraged, and then endorsed, recommendations instead of making firm courses of action themselves"
>
> (Kogan *et.al.*, 1978 p75).

> "Generally speaking, DHAs were involved in issues only when analysis, discussions, negotiations and bargains had produced mature propositions. Their involvement came at a stage where legitimation or endorsement of courses of action agreed elsewhere were necessary. Even on the very rare occasions when alternatives were offered, DHA involvement usually occurred late in the policy process when interested parties had realised that they were unable to agree on a course of action".
>
> (Haywood, 1983 p54)

Commentators, however, are divided as to the precise reasons for this situation. Some have taken the view that the imprecise definition of the Authority itself and therefore the member role creates uncertainties about members powers (Kogan *et.al.*, 1978 p76), which gives rise to role conflict:

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[7] Where members themselves fail to reach this idealised expression of their role, they frequently take refuge in matters of detail at the expense of policy (Farquharson-Lang, 1966 p50; Kogan et al., 1978 p76; Kinston, 1986 p34).

> "Officers and especially chief officers, are appointed on their ability, experience and qualifications as managers. Rightly they regard themselves as being the experts and see their jobs as being not simply to carry out the authority's plans and decisions but more as guiding the authority to make the 'correct' decisions and plans."
>
> (ACAHA, 1981 p12)

Such conflict is often expressed in non verbal 'adversarial' seating arrangements (Haywood, 1983 p18; Haywood & Ranade, 1985 p98). This in turn spawned an essentially political analysis which highlighted the value of the strategies and tactics of inter-personal influence (ibid, p52).

The view thus far depicts officers as filling a void, compensating for the deficiencies of the system or the inadequacy of the laity. An alternative to this depicts officers as active rather than passive actors, a group who display coherent and purposive behaviour. In short, they seek to dominate the lay contribution. Is this conspiracy theory ? To fully understand such a view one must return to an early and seminal analysis of the power structure in the NHS which posited the existence of three sets of structural interests : dominant (the "professional monopolists"), challenging (the "corporate rationalisers") and repressed (the community) (Ham, 1982 p195). While these structural interests retain their validity, a contemporary assessment would suggest that the "corporate rationalisers" now enjoy (near) universal primacy. This arose mainly from

the implementation of General Management (DHSS, 1983) and was further consolidated by the *Working for Patients* reforms. These processes saw the creation of a new and powerful managerial elite:

> "By virtue of their full-time involvement in the running of the Service and their professional and managerial expertise, chief officers were able to exert a significant influence over policy making, often appearing in the guise of policy entrepreneurs, advocating ideas and courses, and actively pushing their own preferences in the policy process"
>
> (Ham, 1986b p126)

This new elite figuratively and literally (ibid, p128) seek to set the organisational agenda. It is unsurprising that this was a source of tension, particularly if one views power as a contestable commodity, in short "the 'them and us' syndrome" (Stewart, 1987b p7).

> "There is potential for mutual mistrust between members and managers, and in a few of the districts in our study that mistrust has become a major feature - sometimes simmering, sometimes spilling over into confrontation or even hostility in private, in public, or both"
>
> (ibid, p7).

Where such tensions exist, they will have been exacerbated by the reform process which saw the transition of some senior managers from officer to Executive director:

> "The arrival of executives into Authority positions is the latest stage in the rise of the NHS manager"
>
> (Ashburner & Cairncross, 1991 p2)

Finally, there is a belief which rejects the conventional wisdom of policy making (Lipsky, 1978; Hunter, 1981) and more particularly takes the view that "the focal point of NHS policy-making is not the Authority, but the officer-member relationship" (Williams, 1981 p10).

Whatever position one takes on officer-member relations - compensatory mechanism, malignant self interest or a critical dynamic - the relationship between these actors will be critical to the success of the reform process.

> "In future, top managers will participate in making decisions they have to implement and they will play an active part in determining strategies and setting priorities"
>
> (Ham *et.al.*, 1990 p21)

This, however, will be complex, as one group within the board (the Non-Executives) discharge their obligation to supervise the remainder (the executive) (Fitzgerald & Pettigrew, 1991 p20). Some dangers remain. At one end of a continuum resides the potential for Non-Executives "adopting superior and interrogative attitudes, and generating defensiveness on the part of executives" (ibid, p28). Alternatively

> "An implication of the inclusion of executive members is that outside the Authority meetings they report to the general manager, but inside the meetings they are all equal. Will executive members be ready to act independently, perhaps against the general manager, or will the general manager effectively hold five votes?"
>
> (Ashburner & Cairncross, 1991 p36)

3.6 The Local Authority Literature.

Having examined the role of the Health Authority member in detail, some consideration will now be given to Local Government. Whilst there are clearly significant differences which separate Health Authority members and councillors, equally there are common themes which make such a comparison worthwhile. What follows is a selective rather than comprehensive review: for a fuller account see, for example, Grayson *et.al.*, 1990.

The first and striking feature to emerge from this literature is an interest in delineating the characteristics of councillors e.g. their calibre, age and class (Drake & Walker, 1990 p52-53), together with factors influencing their performance e.g. average time spent on duties[8] (ibid, p51) or the case for remuneration and support (DOE, 1991 para 29). Implicitly, such considerations reflect a concern with performance although, in the case of councillors, this is made the more complex by their simultaneous constituency, corporate and political responsibilities. If, however, one concentrates upon their corporate role, one view depicts this as follows:

> "The bulk of council and committee work is uncontroversial and officers are more likely to complain about rubber stamping of proposals without deep consideration of the issues by their members..."
>
> (Drake & Walker, 1990 p64)

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[8] The Maud Committee (1967) survey revealed an average of 13 hours a week.

although this does have to be balanced by the differing priorities amongst councillors[9] and the fact that "length of service is positively related to a preference for a wider orientation towards policy-making" (ibid, p53). The evidence also suggests that there may be important cultural differences between urban and rural authorities.

Like Health Authorities, the process of making policy in Local Government has attracted as much if not more interest than the policy outcomes. Conventional wisdom promotes the "principle of mutuality" (Laffin & Young, 1985 p42) in which there is a collaborative and harmonious relationship between officers and members. This contrasts markedly with the more familiar "tensions and anomalies" (Drake & Walker, 1990 p62) which Laffin & Young suggest are intensified by the influence of:

* assertive and younger councillors
* political polarization
* the decline of growth.

These difficulties frequently surface in the policy making process - which the *Bains Report* (1972) characterised as being decided by councillors and implemented by officers - although such a view is now increasingly suspect. In extremis, these difficulties can produce an almost violent

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[9] Drake & Walker (1990, p57) advanced a typology which describe councillors as "parochials", "peoples agents", "policy advocates", "policy brokers" and "policy spokesmen".

rejection of professional advice by members, or the manipulation of agendas and information by officers leading to "technical imperialism" (Drake & Walker, 1990 p67). Although still common, these patterns appear now to be giving way to a more pragmatic view. In some instances, this has produced quite remarkable degrees of co-operation either at a local level (Cloke & Little, 1987) - or within central government (Radcliffe, 1985) - in the interest of a shared purpose and in the presence of trust. In other circumstances, events conspire to produce more overtly *political* Chief Executives:

> "chief officers are coming to see their role as less that of a neutral professional or technocrat and more that of a bureaucratic politician, that is a professional involved in the manipulation of political power"
>
> (Laffin & Young, 1985 p51)

As with the NHS, Local Government is itself undergoing significant change. At the time of writing, the Local Government Review is taking place and although detailed proposals have yet to emerge the thrust of these is likely to centre upon a vision of the future depicted as follows:

> "The people who run local councils increasingly need different skills to meet the challenge of their developing role as enablers rather than providers. The ability to manage large numbers of directly employed staff is becoming less important than the ability to set up and oversee contractual arrangements."
>
> (DOE, 1991 para 5)

This will call for a new organisational culture and management orientation which could encompass either modest changes to the current practice or more radical approaches e.g. a cabinet system, a council manager or directly elected executive. The adoption of any of these latter options would radically redefine the corporate task and management process.

This brief comparison has demonstrated similar concerns with the characteristics and performance of councillors as exist with Health Authority members. Similar too is the central importance of the officer-member relationship, with its ability to be destructive or creative. Also significant is the suggestion that CEOs are becoming more overtly 'political'. In many ways this mimics the role now expected of CEOs/Executive directors in health settings. The major difference resides in the fact that where this occurs in Local Government it is in 'anticipation' of constitutional change rather than as a consequence of it.

- Chapter 4 -

The Literature III: Issues and Experience of Governance in the NHS

4.1 Introduction

As noted earlier, the reforms embodied in the NHS & Community Care Act (1990) created smaller and more "business like" District Health Authorities. Composed of Executive and Non-Executive directors they began, increasingly, to resemble the unitary boards found in the private sector. How did these boards perform ? Did the new configuration begin to produce a level of corporate performance lacking in predecessor bodies ? The answer to these questions is explored through a brief examination of the experience of a number of different authorities: two RHAs, one District Health Authority and one Ambulance Service. What follows is more a series of vignettes than case studies, each of which illustrates the practice of corporate governance extant in the early post reform NHS.

4.2 Cause Celebre

4.2.1 West Midlands RHA The events, subsequently known as the 'West Midlands scandal', began to emerge publicly during the course of 1992 (Limb, 1992; Millar, 1992) and

were, in part at least, confirmed when the Region's Director of Finance "quit" in September 1992 (Anon, 1992). Despite a local inquiry under the chairmanship of the Wolverhampton HA Chairman, Roy Carver, a full description and judgement had to await the publication, in October 1993, of the report of the Committee of Public Accounts (CPA, 1993a).

The report identified a series of "shortcomings" which "led to the waste of at least £10m" (ibid, para 1). This situation arose as a result of the improper engagement of a firm of management consultants to support an unapproved attempt to privatise the RHAs Supplies Division. There were equally flawed dealings surrounding the management buyout of the Region's management services organisation, a subsequent improper loan to what (by then) had become known as Qa Business Services. In addition, the Director of Regionally Managed Services, Mr Watney, had diverted monies due to the District Health Authorities to support *his* management agenda. The report comments that the responsibility for these events,

> "must be shared by the Director of the Regionally Managed Services, Mr Watney, his immediate supervisor the Regional General Manager, Mr Bales, the Finance Director, Mr Davies, and the Chairman and Members of the Regional Health Authority."
>
> (ibid, para 4(vii))

In addition to the presenting problems, the committee also expressed concern about the extent and adequacy of the action taken by the RHA itself. The report expressed disquiet that Mr Watney had been made redundant rather than dismissed, with the nature of the settlement and the (very) limited action taken against others. Only the Director of Personnel was dismissed; the Regional Chairman had resigned, the Regional General Manager had taken premature retirement and the Regional Director of Finance had departed under cover of a "silence" clause (ibid, para 4 (xiii)). The inescapable conclusion of the committee was that there had been,

> "a serious failure by Members of the Regional Health Authority, and in particular the Chairman, in their duty to secure the accountability of regional management"
>
> (ibid, para 4(vii))

and in relation to both Mr Watney and the actions of senior management "a failure to know about and control what their senior staff were doing in their name" (ibid, para 4(xi)). While Mr Watney and management per se were certainly not blameless, the role of the Authority (the board) was clearly central to the committee's thinking and in particular the emphasis they gave to the need for NEDs to be of "sufficient calibre" and for them to have "induction training". Finally, and perhaps particularly with the observation in mind that Mr Watney had been,

> "able to follow his own path, making a bonfire of the rules"
>
> (ibid, para 4(xix))

the committee reinforced the need for staff to respect the standards of "honesty, openness and fair dealing" in public service.

4.2.2 Wessex RHA The 'Wessex scandal' was concerned with events between 1984-1990 and, like the events in the West Midlands, were the subject of private unease and public disquiet. The Authority Chairman, Sir Robin Buchanan, tendered his resignation in August 1993 (Anon, 1993)b. The definitive description and judgement, however, again had to await the publication, in November 1993, of the Committee of Public Accounts Report (CPA, 1993)b.

The report identified a series of events associated with the RHA's regional information system which wasted "at least £20m" (ibid para 3(i)) between 1984 when the project commenced and 1990 when it was finally abandoned. The circumstances involved improper tendering, conflicts of interest, questionable and expensive capital acquisition, and, the inadequate privatisation of the Authority's computer services. All of this was overseen by the then Regional General Manager, Mr Hoare, "a man with strong vision" whose actions were "incompatible with the proper handling of public money and without regard to clear evidence that the project was going badly wrong" (ibid,

para 3(iii)). Whilst the report concluded that Mr Hoare carried the main responsibility for what went wrong and that he concealed information from the Authority,

> "there was a serious failure on the part of the Regional Health Authority to secure accountability from the then Regional General Manager".
>
> (ibid, para 3(iv))

The Authority was also heavily criticised for failing to control its capital budget; the NHS Management Executive were also criticised for failing to act with sufficient urgency.

In addition to the presenting problems the committee also considered and expressed serious concern about the extent and adequacy of the action taken by the RHA. The main criticisms concerned the failure of the Chairman, Sir Robin Buchanan, to act quickly enough, the singular lack of any disciplinary action, the nature of the Regional General Manager's departure, and, severance payments to Mr Hoare and to others. Although the introduction of new procedures and revised standing orders and financial instructions were welcomed, the role of members was the subject of pointed observation,

> "We note that some 16 former members of the Regional Health Authority have not been reappointed, and that the Management Executive are aiming to improve the process for selecting

> non-executive members. We consider that it is essential that non-executive members should be of sufficient calibre and experience to bring independent judgements to bear on the key decisions of the Regional Health Authority. They should also obtain the necessary information to secure the control and effective accountability of the Authority's management. We also note the steps taken by the Management Executive to provide new Chairmen and members of Health Authorities with guidance and training about their responsibilities."
>
> (ibid, para 78)

Finally, the committee underlined the value of proper business conduct and reinforced the need for staff to respect the standards of "honesty, openness and fair dealing".

4.2.3 South Birmingham Health Authority The third organisation to find itself in trouble was South Birmingham Health Authority whose financial circumstances had steadily deteriorated over the period of the late 1980s and early 1990s. As with the two previous examples this was the topic of much debate within the service and, as events unfolded, also the topic of public comment and concern (Moore, 1992). In April 1993 the then Chairman, Frank Graves, was replaced having "turned down the offer of a renewed contract" (Anon, 1993)b. Shortly after the arrival of the new Chairman, Bryan Stoten, the Chief Executive and the Director of Finance left the Authority. A full account of the difficulties and a judgement upon those concerned was (again) the topic of a report, in July 1994, of the Committee of Public Accounts (CPA, 1994)a.

In essence, South Birmingham Health Authority found itself in the position of having a "forecast in-year deficit... of £16m for 1992-93" (ibid, para 4(i)). This was exacerbated by some £3m of debt being written off (ibid para 4(iii)) and events deteriorating to the extent that loans had to be made to the Authority in order for it to pay its creditors within an eight week period (ibid, para 4(v)). The reasons for these circumstance are complex but included: a long standing and underlying financial weakness in the Authority and its predecessors, the effects of a proposed city-wide rationalization of health service provision, and, the combined effects of merger and the implementation of the NHS reforms which took effect, simultaneously, from April 1991.

Responsibility was almost as difficult to define as the problem. However, the committee took the view that the Chief Executive, Mr Dickens, and the Director of Finance, Mr Jones, were guilty of "obfuscation" and that they,

> "should have been much more accurate in their handling of the Authority's financial position which amounted to [a] loss of control and poor management"
>
> (ibid, para 4(x)).

In addition, the committee were critical of the monitoring role of the RHA and the NHS Executive. This is clearly an echo of the earlier reports and a further condemnation of the West Midlands RHA which was, in any event, experiencing its own internal difficulties (see 4.2.1 above). The

failure to adequately monitor was seen both as central to the development of the problem and to the lack of progress towards a full and final resolution. In paragraph 4(xx)-4(xxviii), the committee expressed concern about the disciplinary action taken against the Chief Executive and the Director of Finance and the nature of severance payments - in these cases and more generally throughout the NHS.

In this case the 'villains' were clearly seen to be the Chief Executive and the Director of Finance but, curiously, the report made no reference to the role of the District Health Authority itself. It did, however,

> "welcome the decision to issue codes of conduct and accountability for NHS boards and the NHS Executive's programme aimed at raising the quality and professional competence of the finance function in health authorities."
>
> (ibid, para 4(xviii))

As a footnote to the Committee of Public Accounts report, the full financial outturn in South Birmingham was probably closer to £30m than the £16m reported in 1992-93. The Authority did, however, succeed in achieving an income and expenditure balance by March 1995.

4.2.4 The London Ambulance Service This example differs from those above in so far as it stemmed initially from a single incident - the near collapse of the capital's ambulance service - in October/November 1992. The Secretary

of State intervened directly and the then Chief Executive, Mr Wilby, resigned, after which an investigation was put in hand to discover exactly what had gone wrong.

The first of two reports was published some four months later (Page, 1993), at which point the Chairman of the LAS board, Mr Harris, resigned. The presenting problems concerned the specification, procurement, project management and eventual collapse of the computer aided dispatch (CAD) system, all of which had taken place against a backdrop of poor industrial relations, unhappy local MPs and a vocal media. Although there are many important technical dimensions to these difficulties, the fundamental problems were managerial, in managements relationship with the LAS board, and, in the boards relationship with the RHA.

The LAS was founded in 1930 and became the responsibility of the NHS in 1994, since when it had been managed by South West Thames RHA. The RHA created a non statutory "arms length" board in 1990 which was accountable to the RHA, but responsible for the day to day management of the LAS. The RHA appointed a LAS Chief Executive, Mr Wilby, in August 1990. He was *employed* by the RHA but accountable to the LAS board and its Chair, and through them to the Regional General Manager.

The report shows that the board and senior RHA managers were frequently misled by a forceful Mr Wilby, in so far as "the budget for the CAD project and the original deadlines... were set by the Chief Executive without discussion with the LAS Board" (Page, 1993 para 6070). The report continued,

> "in practice the LAS Board was not given sufficient information to exercise the responsibilities delegated to it by South West Thames RHA for the day to day management of the LAS. Neither was it apparent that they actively sought such information"
>
> (ibid, para 6071).

In a subsequent press interview, Dennis Boyd, a member of the inquiry team commented,

> "they [the RHA] appointed people to the board who were probably not sure of their responsibilities. Some of the decisions were clearly rubber stamping."
>
> (Butler, 1993(a) p10)

The Regional General Manager believed it important "not to interfere" (Page, 1993 para 6072).

Unsurprisingly, the report's recommendations - or at least those concerned with encouraging accountability - sought clarification of the role of the LAS board and its relationship to the RHA, the need for the board to reserve certain decisions unto itself, the accountability of executive directors, and, the need for improved performance

management (Page, 1993 para 6073). The report also recognised the need to more actively manage relationships with stake holders (ibid, para 6076).

Progress within the LAS was not altogether satisfactory (Butler, 1993b) and, following the death of eleven year old Nasima Begum in June 1994, a second inquiry was established and subsequently reported (Wells, 1995). As one observer commented at the time the LAS was:

> "beset by continuing management weakness, poor communications, outdated working practices and above-average sickness absence, and is virtually without modern technology"
>
> (Chadda, 1995a p15)

It is not appropriate here to explore, in full, all the circumstances which prevailed or all of the inquiry's findings but rather to concentrate upon those which pertain to executive management and to governance.

Despite the strengthening of the board (Wells, 1995 p15) there still appeared to be difficulties associated with purpose, culture and the management of change (ibid, p16). This slowness to turn plans into action it was suggested was due to:

> "The fact that LAS Directors are not responsible for the organisations own destiny on many important matters [which] has led to a lack of incisiveness"
>
> (ibid, p16).

The report made many recommendations for remedial action, the most surprising of which was to propose that consideration be given to the LAS becoming an NHS Trust from April 1996! This stratagem of 'devolving' the problem still further was in stark contrast to the criticisms only a few weeks later by the Commons health committee. They were critical of both the Regional General Manager, Mr Sprey, (Chadda, 1995b p7) and junior health minister, Tom Sackville, (Anon, 1995a p6) for inadequate progress and failure to adequately monitor, respectively.

4.3 A Changing Climate 1993 had seen the publication of three of the above five reports, with all the attendant publicity and political rough and tumble that such revelations were bound to provoke. It had been a bad year for the NHS. Tabloid and broadsheets alike were questioning the policy legacy of the Thatcher administration and the validity of imported private sector practice and values into the NHS. This took place against the backdrop of the (then) recently published report into *The Financial Aspects of Corporate Governance* (Cadbury, 1993) - itself a response to corruption and bad practice in the private sector. The report and its recommendations subsequently became the 'gold standard' against which governance in the NHS and other public sector organisations was tested, and frequently found wanting.

This sense of internal and external unease coalesced, in January 1994, with the publication of *The Proper Conduct of Public Business* by the Commons Committee of Public Accounts (CPA,1994)b. It was a defining moment, in the sense that it articulated and focused a widespread sense of dissatisfaction with what appeared, increasingly, to be the common place rather than the exceptional. The headline in The Independent the following day proclaimed a "cancer of corruption" (Blackhurst, 1994)

The Committee of Public Accounts had, all too frequently, found itself investigating unsatisfactory performance by public bodies. In this single slim volume the Chairman, Robert Sheldon MP, reinforced the importance of "proper standards... in the conduct of public business" (CPA, 1994b para 3). The report also firmly rejected any holding back of the drive for economy and efficiency or any relaxation of traditional standards.

> "We emphasise that we are not calling for any more detailed rules. Almost every case we have examined involved breaches of existing rules or guidance. But detailed rules must be set in a framework in which those to whom authority is delegated are told in unambiguous terms the scope and limits of the delegation. And that framework must include effective systems of control and accountability and above all responsible attitudes on the part of those handling public money."
>
> (ibid, para 6)

The committee identified the most common areas of failure:

* inadequate financial controls
* failure to comply with rules
* inadequate stewardship of public money and assets, and,
* failure to provide value for money

together with a 'good practice' checklist (ibid, annex 1). The remainder of the report identified twenty six examples of "instances of failure" in the NHS and other public bodies against the above headings. It was a salutary lesson.

4.4 An NHS Riposte

The NHS was clearly and keenly aware of the governance difficulties it faced at a number of levels and from mid 1993 a concerted and coherent effort to resolve these problems was discernable. As early as January the NHS Management Executive published guidance "to assist NHS employers and staff in maintaining strict ethical standards in the conduct of NHS business" (HSG(93)5). This guidance ranged over the acceptance of gifts and hospitality, declarations of interest, preferential treatment, contracts, favouritism and sponsorship etc.

Rather more broadly based thinking emerged during the summer of 1993 when the NHS Management Executive began,

publicly, to acknowledge both the Cadbury Report and the importance of corporate governance. In June Health Secretary, Virginia Bottomley, announced the establishment of a Corporate Governance Task Force - a major initiative within the NHS and a clear response to the (still escalating) difficulties in this area. The Chief Executive of the NHS, Sir Duncan Nichol, later remarked rather enigmatically, "experience in the NHS indicated that matters stood in need of reassessment" (Nichol, 1993)

The Task Force of senior service figures, academics and practitioners set about their task in the summer of 1993. They published draft proposals in January 1994 which were subsequently accepted and implemented with effect from April 1994. The Task Force consisted of a sixteen strong steering group who directed and co-ordinated the efforts four Working Groups concerned with:

* the reinforcement of public service values
* matching the role and functions of Chair and Non-Executive directors with their part-time commitment
* the induction and training of chairmen, Non-Executive directors and the board as a whole
* the role of Non-Executive directors in finance and audit.

(NHSME, 1993)b

The main achievement of the Task Force was the creation of the Code of Conduct and the Code of Accountability which were published in April 1994 (DOH,

1994). The **Code of Conduct** promoted the "crucial" public sector values of accountability, probity and openness but otherwise largely reiterated and reinforced earlier guidance concerning openness, management practice, public business and private gain, hospitality, relations with suppliers etc. The **Code of Accountability** although synthesising some existing direction sought to set out an 'unambiguous framework' for NHS bodies. The code clearly established a framework of accountability for health bodies - NHS trusts and authorities - before going onto the role of the board, the Chair and Non-Executives. Other important issues covered reporting and controls, declaration of interests and employee relations.

Although both codes were a necessary - and subsequently mandatory intervention - they focused rather too much on what Hilmer & Tricker (1991) have described as boards "conformance roles" with much less attention being given to the "performance roles". Also, in terms of balance, most attention was devoted to Chair and Non-Executive directors, least (explicitly) to Executive directors. While this can be readily understood against the backdrop of the West Midlands and Wessex scandals, in the event the view of corporate governance to emerge was partial and unbalanced. The codes have also been criticised for being "rarely specific" in terms of the behaviour sought of directors (Hodges & Starkey, 1995 p5) but, in fairness, much detailed guidance was issued simultaneously

on audit and remuneration committees, annual reports etc. (EL(94)40); also associated guidance in respect of finance (EL(94)18; EL(94)38).

Another, but more broadly based code, the *Code of Best Practice for Board Members of Public Bodies*, was published in June 1994 (HMT, 1994) and exhorted public bodies to:

* observe the highest standards of impartiality, integrity and objectivity
* demonstrate openness
* be accountable, and,
* maximise value for money

with the remainder exploring the relationship with sponsoring departments, looking at the role of the Chair and board members and their financial and other interests. Emphasis was also placed upon accountability for public funds, audit and audit committees, openness and reporting. Interestingly, this code also identified the role of the "accounting officer" (ibid, p9) - a concept subsequently adopted by the NHS.

4.5 From Performance to Values ?

If the concern about the exercise of corporate governance in the public service in the early 1990s was concerned with the performance of boards, the focus of the mid 1990s was with values. Here two sets of forces - one concerned with a growing 'quangocracy' and the other with

falling standards of personal behaviour in public life - came together. The former is best articulated by Stewart who fears the growth in the size of the unelected state and the effect this has upon the democratic process (Stewart, 1992; Ranson & Stewart 1994). In the health field this concern has existed for some time (Regan & Stewart, 1982; Haywood 1985), but is again re-emerging in the light of the contemporary debate (see for example Plummer, 1994; Hunter, 1995).

The second tranche of concerns about values sprang from what was widely believed to be the rapidly deteriorating standards of personal conduct in public life. This view emerged following a litany of exposes concerning standards of probity in public service (see e.g. Blackhurst, 1994) and concerns about standards of personal and ethical conduct by members and former members of Government (Biltz, 1994). The public debate and political pressure - in the face of what quickly became know as "sleaze" - was such as to force the Prime Minister to establish, in October 1994, a Committee under the chairmanship of the Lord Nolan. The committee's brief being,

> "To examine current concerns about standards of conduct of all holders of public office, including arrangements relating to financial and commercial activities, and make recommendations as to any changes in present arrangements which might be required to ensure the highest standards of propriety in public life."
>
> (Nolan, 1995a)

The committee took written and oral evidence largely focusing upon,

* members of parliament and their financial interests
* ministers and civil servants
* QUANGOS

(Nolan, 1995b)

and published its first report *Standards in Public Life* (Cm 2850-1) in May, 1995.[1]

Standards in Public Life was an important contribution to this critical debate, in particular it offered a measured consideration of the context of public service and allegations of sleaze, and, addressed several specific areas in some detail. For the purpose of this research, the detailed consideration will concern quangos.

In the introduction to his report the Lord Nolan steered a careful course between tabloid frenzy and a reactionary response to what had clearly been a disturbing series of a priori events. Nolan set the moral tone in stating that "a degree of austerity, of respect for the

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[1] The author was fortunate enough to have a 'source' within the PAC who was kind enough to discuss the issues and provide information on an 'informal' basis during their deliberations of the matters reported in this chapter. In addition, abridged reports of the pilot study and the full postal questionnaire were, respectively, supplied as evidence to the NHS Corporate Governance Task Force and to the Nolan Committee.

traditions of upright behaviour in British public life is not only desirable, but essential" (CM 2850-1, 1995 para 7). This was augmented by the seven principles of public life - selflessness, integrity, objectivity, accountability, openness, honesty and leadership - which were seen to be appropriate (and necessary) standards in public life. These principles were seen to apply equally to both individuals and institutions. In this latter regard Lord Nolan recognised and reinforced the value of codes of practice, independent scrutiny, together with guidance and education (ibid, paras 14-17).

In Chapter 4 of his report Nolan considered in detail the issues and concerns surrounding appointments to and the functioning of quangos. These bodies are defined as, "local bodies which are independent or self governing, but which spend public money and perform public functions" (ibid, p67). In all there are 600 NHS bodies, involving 5,015 appointments and spending £25bn. The chapter proposes action on appointments and propriety. In terms of appointments Nolan concluded "we do not find the case for change proven (ibid,p72) but determined...

* Appointments to boards of executive NDPBs and NHS bodies should be made on the merit, to form boards with a balance of relevant skills and backgrounds.

* Responsibility for appointments should remain with Ministers, advised by committees which include independent members.

* A Public Appointments Commissioner should be appointed, to regulate, monitor and report on the public appointments process.

* The process should be open and departments should have to justify any departures from best practice. Job specifications should be published, and a wide range of candidates should be sought. The suitability of each candidate should be assessed by an advisory committee.

(ibid, p65)

and in regard to propriety...

* It should be mandatory for each executive NDPB and NHS body to have a code of conduct for board members, and a similar code for staff.

* A review should be undertaken by the Government with a view to producing a more consistent legal framework governing propriety and accountability in public bodies including executive NDPBs, NHS bodies and local authorities.

* Openness and independent monitoring are important safeguards of propriety, and should be extended. In particular staff should have a confidential avenue to raise any concerns about issues of propriety.

* The responsibilities of accounting officers for propriety as well as financial matters need to be emphasised. Audit arrangements should be reviewed to ensure that best practice applies to all public bodies.

(ibid, p65)

This chapter has set out the early experience of governance in the NHS, in particular in the period proceeding and immediately following the *Working for Patients* reforms. From this experience it is clear that policy was imprecise, and, personal conduct fell far short of what was required, the combined effects of which led to some spectacular governance failures. It is important to

recognise, however, that such difficulties were not confined to the NHS - see chapter 6 - some of which share common origins and features.

The circumstances in the NHS initially prompted a (largely internal) concern with performance, but, as the difficulties worsened, public opinion emerged as an increasingly influential factor as concern widened and deepened. The focus moved rapidly from performance to values and the standards of personal conduct - or their absence - at the centre of the governing/governance agenda addressed by Nolan. There was, and to some extent remains, a suspicion that some of these ills stemmed from the adoption of private sector practices. For this and design reasons it is important to consider the nature of corporate governance in the private sector, a matter to which we turn.

- Chapter 5 -

The Literature IV: Corporate Governance in the Private Sector

5.1 Corporate Governance

The dominant model for the management of public companies throughout much of the western world is that of the board and through it the exercise of corporate governance. So widespread is this approach and such are the similarities with reformed Health Authorities that an exploration of this literature is central to this study.

It has been said that one of the most significant systems ever created was the joint stock limited liability company (Tricker, 1990a p65). Prior to this all ownership patterns - sole traders, partnerships or unlimited/unincorporated companies - were personally liable for *all* of the debts they incurred. Limited liability changed this by establishing:

* the separation of the business from its owners
* the creation of a legal persona for the company
* the affirmation that ownership was the basis of power, and,
* the limitation of ownership liability.

(Tricker, 1993a)

These measures created the incentives for investment and thus the pattern of wealth creation central to modern capitalism. These changes, which took place in the 19th century - The Joint Stock Companies Act 1844 and the Companies Acts 1855 & 1862 - were to be the dominant influence upon such matters throughout the then British Empire and were also a significant influence in North America (Tricker, 1990b).

The legal system in France and Germany, which was rooted in Roman Law, evolved their respective approaches via rather different routes. A significant difference being the existence of unitary boards in the UK, USA and Asia and the two tier board in Western Europe, particularly Germany. Conceptions of organisational form and governance patterns are, however, more than just a product of the legal framework. They also reflect cultural and ideological differences (Sheridan & Kennedy, 1992; Tricker, 1993b and 1994a; Charkham, 1994; Clarke & Monkhouse, 1994).

Perhaps the simplest meaning of corporate governance is "the purpose and methods of how we structure and control companies large and small" (Midgley 1982, p vii). A more comprehensive definition, however, holds that:

> "the governance role is not concerned with running the business of the company, *per se*, but with giving overall direction to the enterprise, with overseeing and controlling the executive actions of management and with satisfying legitimate expectations for accountability and

> regulation by interests beyond the corporate boundaries. If management is about running business; governance is about seeing that it is run properly. All companies need governing as well as managing"
>
> (Tricker, 1984 p6)

These are the functions found in no other part of the organisation than in its governing body. Frequently part time and physically removed, the board is an amalgam of individuals at the end of the accountability line acting as the agents of a largely unseen principal (Carver, 1990 p18). The scope of corporate governance is therefore concerned with:

> "the way corporate entities are governed, as distinct from the way businesses within companies are managed. Corporate governance addresses the issues facing boards of directors, such as the interaction with top management, and relationships with the owners and others interested in the affairs of the company, including creditors, debt financiers, analysts, auditors and corporate regulators. Concern about corporate performance through involvement with strategy formulation and policy making, and about corporate conformance through top management supervision and accountability to the stakeholders fall into the field of governance."
>
> (Tricker, 1994b p xi)

5.2 Ideas and Theories in Corporate Governance.

Much of the debate and the early literature about the ownership and control of private sector organisations was inhabited by politicians, economists and, rarely, academics e.g. Berle & Means (1932). Contemporary analysis, however,

largely dates from the innovative study of American boards by Mace (1971) who suggested that much of the received wisdom concerning board practice was not demonstrated in practice. The quiescent nature of such investigations being largely explained by there being little or no interest, or need, to investigate such matters and the relative difficulty of penetrating such institutions for the purpose of study. From such beginnings, however, the literature burgeoned. Lorsch & McIver (1989) confirmed Mace's earlier conclusions; others identified that directors did not always act in the best interests of their shareholders (Kesner & Dalton, 1985; Waldo, 1985). Other studies revealed the contestable nature of boardroom power and the tendency towards domination by individuals or groups (Spencer, 1983; Tricker, 1978 and 1984; Aris, 1986). A comprehensive review of the corporate governance literature is provided by Cochran & Wartick (1988).

The definition of a company and the nature of governance are rooted in law.

> "The theoretical underpinning is normative, based on the belief that stewardship will be exercised by the directors... to whom the company has delegated responsibility and authority, while requiring appropriate accountability."
>
> (Tricker, 1994b p4)

This **stewardship theory** is predicated on the notion of the just and honest man acting in the best interest of others within a legal framework. More recently the emergence of

agency theory has been put forward as an alternative view of corporate governance. The firm is presented as a complex inter-relationship between the 'principals' (shareholders) and their 'agents' (the directors).

> "Agency theory argues that agents will act with rational self interest, not the virtuous, wise and just behaviour assumed in the stewardship model. Consequently checks and balances are needed, with their inevitable agency costs, to counteract potential abuses of power."
>
> (Tricker, 1994b p4)

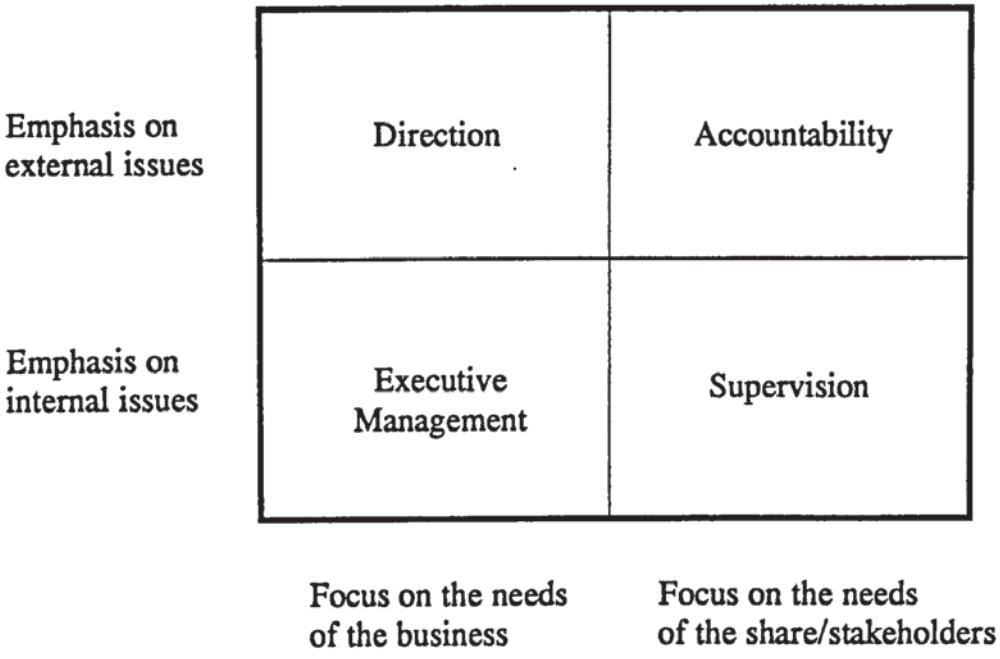
5.3 The Dimensions of Corporate Governance

But what do those engaged in corporate governance actually do ? Waldo contends that governance has three dimensions i.e. "legitimizing", "auditing" and "directing" (1985, p17). A richer and a more comprehensive view is reflected in Tricker's model of corporate governance - see **Fig 5.1** This he summarised as follows:

> "Setting the corporate direction provides strategies, policies, projects and plans which guide and constrain ongoing executive performance; which can then be monitored, supervised and controlled, with overall accountability, both for longer term strategic direction and current performance."
>
> (Tricker, 1984b p176)

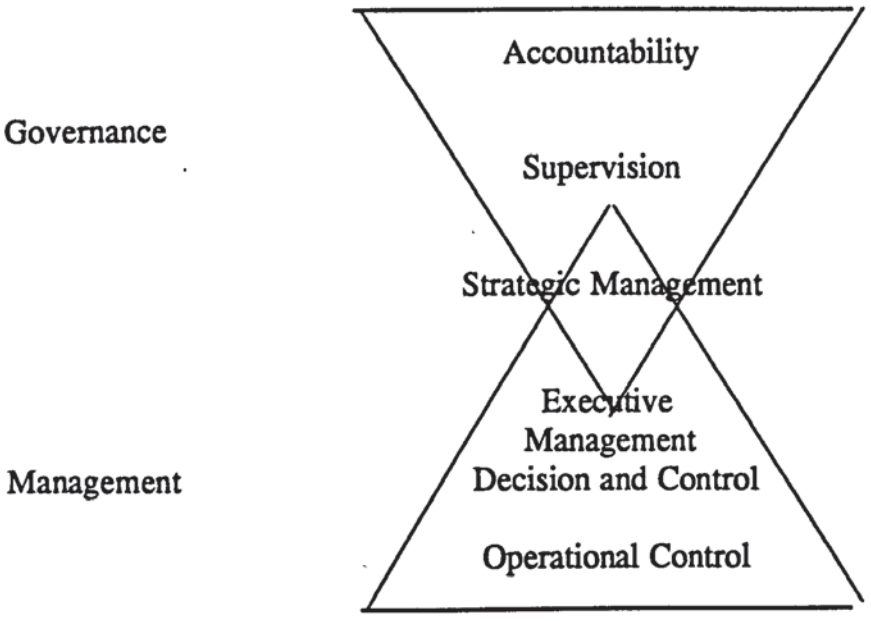
It follows that although executive management is a part of governance, governance is much more than simply executive management writ large. Tricker makes this point nicely - see **Fig 5.2** - clearly demonstrating the interface between governance and management.

Fig 5.1
A conceptual Model of the Activities of Corporate Governance



Source: Tricker (1984, p174)

Fig 5.2
The Activities of Governance and Management Compared



Source: Tricker (1984, p7)

It is important at this juncture to give a rather fuller account of the dimensions of governance. Central to the concept is the notion of **direction** which involves:

> "the formulation of strategy and the acquisition and allocation of resources, setting policies which guide and constrain management action and broadly establishing the direction the company is to take. It emphasises the mission of the business - the shared vision of possible futures and desirable directions for the enterprise."
>
> (Tricker 1984b, p175)

The sense in which direction or path finding is pursued begs the question : in whose interest ? In the proprietary company it is the economic interests of the owner which predominate. In all others, however, there is a separation between ownership and management and - in the case of public companies - between those and investment. It is precisely because of this that **supervision** is a critical component. Carver talks of the "moral ownership" of organisations (1990, p130) but as the regular city and other scandals testify, this may not be enough. For these reasons and due to "the dominance of the executive" (Charkham, 1986 p447) it is important that outside directors be closely involved in the accounts, the election of outside directors and the remuneration of top executives (ibid, p448). In this way the interests of share holders - or in the case of the not for profit organisations, stake holders - can be represented. This is the *fiduciary* role which, almost without exception, has the force of law.

In parallel with supervision is the concept of **accountability**. Tricker says of corporate accountability that it is "the duty a company owes to be accountable to those parties which can exercise the right to demand that accountability" (1984b, p125). This is usually taken to mean the shareholder interest but can also include employees, customers and the community at large. Despite the growing importance of 'social accountability' (Clutterbuck *et.al.*, 1992), this is an idea which is often seen to hinder entrepreneurial instincts and at the level of individual behaviour, problematic. However difficult, accountability is an inescapable obligation involving rights and duties, not interests and options. Finally, the most familiar element, **executive management** is concerned with "shorter term operational matters of financial, production and market management" (Tricker, 1984b p175). It is here that management and governance overlap - see again **Fig 5.2**[1].

Much of the literature discussed thus far has been drawn from the commercial element of the private sector. There is, however, a growing literature in the realms of not-for-profit and voluntary organisations. Whilst this is not as substantial or influential as the 'commercial'

---

[1] Although a limitation of the Tricker model could be that it fails to fully distinguish between the contribution of the board and that of the individual director, this is not considered to be a serious weakness. In any event - in research design terms - the survey data is likely to illuminate the collective activity of boards and the case studies the individual experience of directors.

literature, it may have some significance for governance in a public sector context. Upon examination, the differences are in emphasis rather than substance. One difficulty that can arise is having a 'possessive' Chief Executive who dominates the board and perhaps, therefore, the organisation (Waldo, 1985 p34). Such a situation would raise questions concerning direction and executive action. Perhaps the greatest difference, however, is in terms of stakeholders:

> "Every non-profit organisation has a multitude of constituencies and has to work out the relationship with each of them."
>
> (Drucker, 1990 p123)

As above, this too has a consequence, on this occasion for supervision and for accountability. As Drucker observes, "membership [of a board] is not power, it is responsibility" (ibid, p124). The voluntary sector faces many of the same dilemmas but tolerates (perhaps even encourages) much greater organisational and managerial diversity (Harris, 1992 p134). The rejection of anything approaching a common pattern being as much a statement of their independence of mind as of fundamental heterogeneity.

One important component of the private sector literature is the process dimension, a viewpoint significantly absent in the core literature. The single most important contribution here is the work of Anne

Spencer. In her study of "outside" directors she adopts an interactionist approach to role theory and in so doing depicts a process of role negotiation,

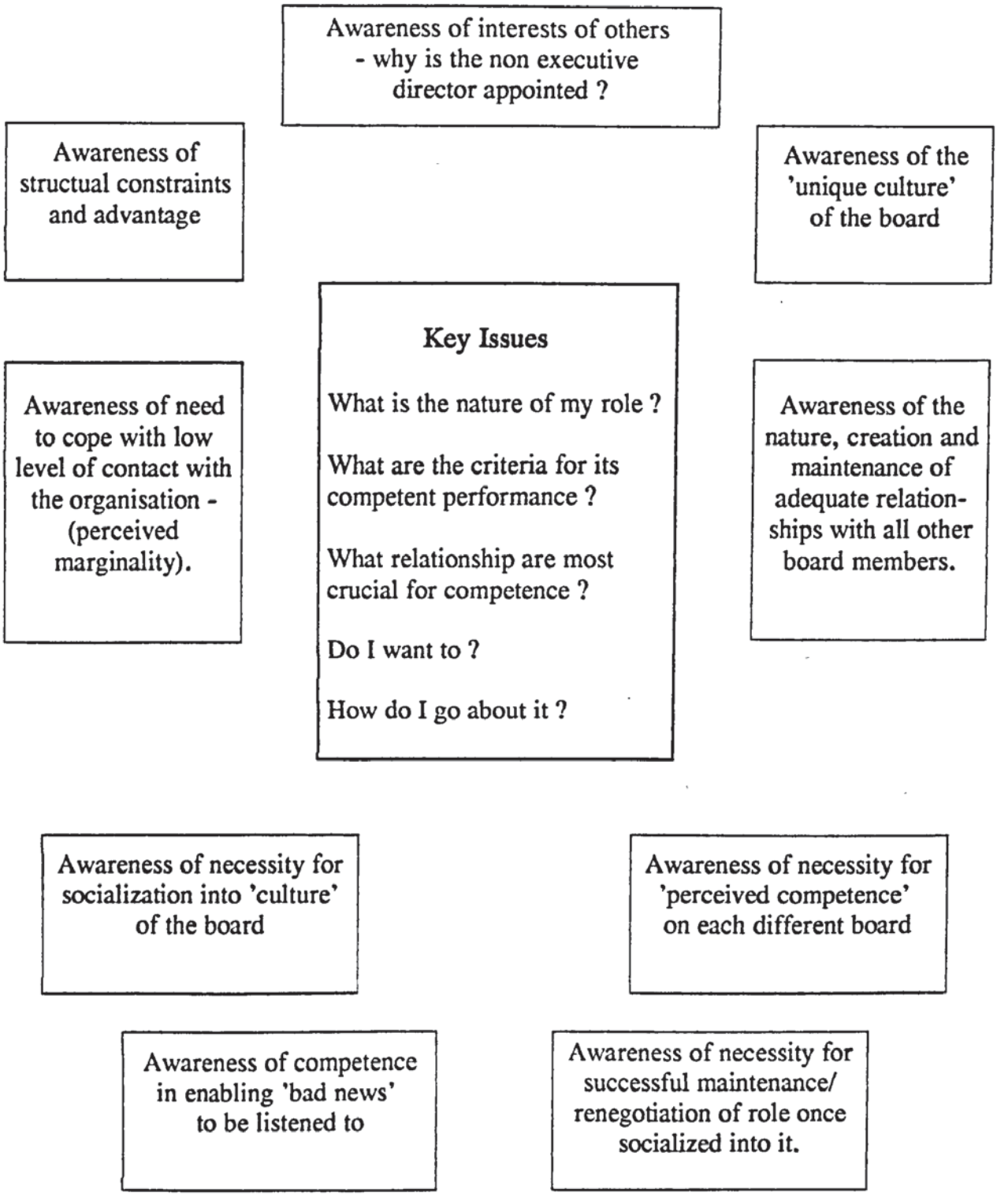
> "The issue can be broken down into 'social' competence, that mastery of the collective symbolism that a member must possess and be seen by others to possess, as a prerequisite for being permitted to attempt role performance, and 'technical' competence, the range of abilities an actor must have to produce a competent role performance once the role is acquired."
>
> (Spencer, 1983 p119)

She draws upon this and other material to develop a "theory of being a non executive director" - see **Fig 5.3** Equally others have emphasised the importance of boardroom norms in shaping cohesive action (Lorsch, 1990 p53). What is clear is that an understanding of how boards operate can be informed by sociological and psychological precepts.

5.4 Role and Duties of Directors

It follows from the above consideration of the dimensions of corporate governance that directors need to fulfil a given role and discharge specific duties consistent with such a formulation. The reality, however, will be shaped by the type of board, the nature of the business, and of course the attributes of the directors themselves. Directors encompass both Executive and Non-Executive directors but the literature, generally, tends to

Fig 5.3
A Model for the Theory of being a Non Executive Director



Source: Spencer (1983)

be rather more concerned with the latter and in particular their relationship with Executives. Demb & Neubauer (1992) do, however, take a wider view and consider the differential contribution of both Executives and Non-Executives - see **Fig 5.4.**

Fig 5.4
Board Contribution by Type of Director

	Company/ Industry	**Breadth/ Context**	**Involved/ Interested**	**Detached/ Indept.**
INSIDE				
Executive	+	?	+	-
CEO	+	?	+	-
Former Ext	+/-	?	+	?
Chair/CEO	+	?	+	-
Chair/f.CEO	+	?	+	?
OUTSIDE				
NED	?	+	-	+
Chair/NED	?	+	-	+
Long Term NED	+	+	?	+
Prof NED	?	+	+	?
Institutional	?	+	?	?

Source: Demb & Neubauer (1992, p108)

Rather more typical is the narrower view of, for example, Sheridan & Kennedy (1992, p150) who focus upon the supervisory responsibility of Non-Executive Directors in the context of a "supervisory 'council'" *within* the board. This they envisage being exercised by:

* watching out for trouble
* preparing for a crisis (and often taking over the reins in a crisis of confidence or leadership)
* appraising the Chief Executive
* forming a judgement about the next Chief Executive
* setting standards of performance, and the culture of the company
* influencing and being involved in strategy
* overseeing compliance, and,
* overseeing and controlling the pension fund arrangements.

Although doubtless this reflects a narrow reality for some boards it is an incomplete picture. By contrast a much more elegant view is advanced by Tricker (1994b, p98) who identified two broad areas of director responsibility:

Performance Roles

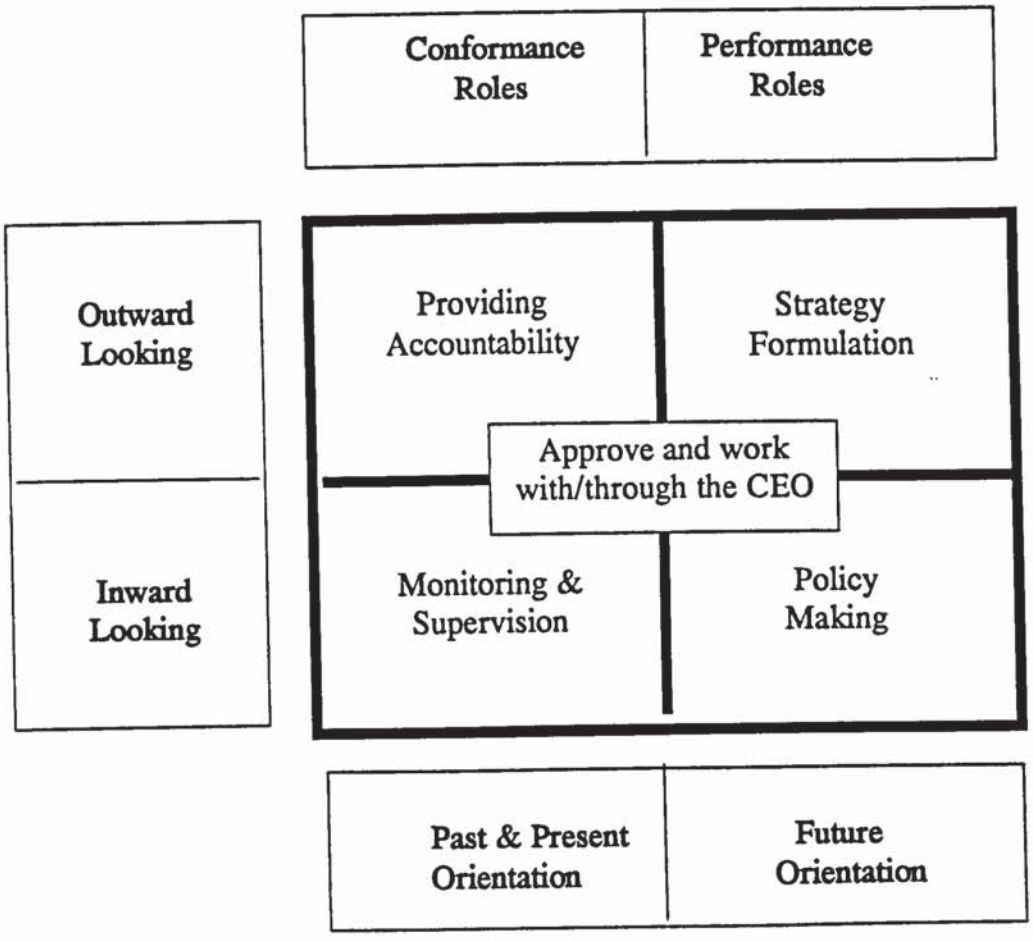
* contributing know-how, expertise and external information
* networking, representing the company and adding status

Conformance Roles

* judging, questioning and supervising executive management
* watchdog, confidant and safety valve.

which has the virtue of being consistent with his model of corporate governance (Tricker, 1984) - see **Fig 5.5.**

Fig 5.5
A Framework for Analysing the
Primary Functions and Activities
of Boards



Source: Hilmer & Tricker (1991)

In addition, in almost all jurisdictions, directors have an obligation to behave with honesty and integrity i.e. the fiduciary role. This requires that they "act honestly [and] in good faith, giving all shareholders equal, sufficient and accurate information" and, in addition "exercise reasonable care, diligence and skill in their work on the board" (Tricker, 1994b p101). The extent to which directors, particularly Non-Executive Directors, are able to fulfil these and other responsibilities is constrained by time, information and power (Tricker, 1992 pA6/8-A6/10).

5.5 Board Effectiveness

Whatever the context, whatever the theoretical base, the private sector literature is also concerned with board effectiveness. The validity of such concerns is self evident, particularly in the face of what can frequently go wrong:

* time spent on trivial matters
* short term basis
* reactive stance
* reviewing, rehashing and redoing
* leaky accountability
* diffuse authority

(Carver, 1990 p10)

As with the core literature, a logical expression of effectiveness is a desire to show board members whose characteristics and training make this more rather than less likely. Important attitudes include:

* competence as a director
* ethics
* ambassadorship
* independence
* preparation
* director practice
* committee service
* corporate development
* attendance (Waldo, 1985 p31)

Given these concerns boards should, on a regular basis, review their progress with and approach to corporate direction, executive action, supervision and accountability and make whatever adjustments are judged necessary. The suspicion of more profound difficulty should provoke an audit of board structure and membership, board process and style, board practices, and, board development and director training (Tricker, 1984b p261). The change or intervention such a strategy reveals should then be pursued with vigour.

5.6 Corporate Governance: Growing Interest and Concern

Until comparatively recently there was little real

interest in matters of corporate governance by academics which explains - with some notable exceptions - the impoverished nature of the literature prior to the mid 1980s. Thereafter the picture changed, interest grew and the literature burgeoned. In terms of the UK, the most significant contribution is that of Tricker whose work has made a singular contribution to the understanding of corporate governance both in a European and more recently Asian context. Why, however, has interest in the field grown ?

More than anything else a (almost regular) diet of scandal has shown how vulnerable the practice of corporate governance is to corrupt and/or illegal acts. Again, in a UK context, the business dealings of BCCI, Guinness and Poly Peck have become synonymous with corporate criminality in the minds of the public; so-called 'white collar crime'. The most notorious example of such corporate skulduggery is, however, the Maxwell case - a testament to greed, corruption and the abuse of power on a vast scale (Stiles & Taylor, 1993; Clarke, 1993).

The net effect of this litany was the establishment by the Financial Reporting Council, the London Stock Exchange and the accountancy profession in May 1991 of the Committee on the Financial Aspects of Corporate Governance. The committee, under the chairmanship of Sir Adrian Cadbury, issued a draft report in May 1992 and a final report in

December 1992 (Cadbury, 1992). The Cadbury Report was predominantly concerned with the financial aspects of corporate governance. Rather better known, however, was the accompanying volume *The Code of Best Practice* which focused specifically upon the board of directors, Non-Executive directors, Executive directors and upon the issues of reporting and control - see **Fig 5.6.**

The Report and Code were, for the most part, welcomed and soon became the epicentre of the debate about corporate governance. However, such criticisms as existed, were summarised thus:

* "The Report and Code are too draconian, offset by others saying that it lacks teeth.

* The Code is too burdensome for smaller listed companies.

* It would not have stopped Maxwell.

* Auditors are let off too lightly.

* Our recommendations on Non-Executive Directors will divide the board and undermine the unitary principle."

(Cadbury, 1994 p46)

The voluntary Code came into force in June 1993 and was formally reviewed two years later in June 1995.

Fig 5.6
The Code of Best Practice
The Financial Aspects of Corporate Governance

The Board of Directors

* should meet regularly
* the role of the chairman and CEO should be separate
* the board should contain Non-Executive Directors
* the board should have a schedule of matters specifically reserved to it for decision
* directors should have access to the advice of a company secretary

Non Executive Directors

* Non-Executive Directors should bring to the board independent judgement
* the majority of Non-Executive Directors should be independent of management
* Non-Executive Directors should be appointed for specified terms
* Non-Executive Directors should be selected formally

Executive Directors

* directors contracts should not exceed three years
* there should be full disclosure of directors' emoluments
* executives pay should be subject to the recommendations of a remuneration committee

Reporting and Control

* the board should present a balanced and understandable assessment of the company's position
* the board should ensure an objective and professional relationship is maintained with the auditors
* the board should establish an audit committee
* the directors should make their responsibilities in respect of the accounts clear
* the directors should report on the effectiveness of internal controls
* the directors should report upon the business as an on-going concern

Source: Cadbury (1992, p16)

In the aftermath of the first Cadbury Report the issue to replace criminality as a source of public concern was that of executive pay. This (re)emerged as an issue in the first half of 1995 with the announcement that Cedric Brown, the Chief Executive of the (then) recently privatised British Gas, had been awarded a 28% salary increase to raise his basic remuneration to £475,000. Shortly after, Lord Alexander, the Chairman of Nat West, was to receive a £100,000 performance bonus. The media and political debate which ensued prompted the CBI to establish, in January 1995, a committee under the chairmanship of Sir Richard Greenbury (the Marks & Spencer Chairman). The Greenbury Committee was to examine the whole issue of executive pay and executive share options schemes (ESOPS) and reported in July 1995. The main points to emerge from the Greenbury Report included:

* listed companies should comply with new Code of Best Practice "to the fullest extent practicable" and make annual compliance statements.
* London Stock Exchange should oblige listed companies to introduce the code's provision.
* Investor institutions should use their "power and influence" to ensure implementation of the code.
* Privatised utilities should "review comprehensively" remuneration packages and "adjust them on a voluntary basis as necessary".
* No share option grants should be made for any newly privatised company for at least six months after privatisation.
* Gains from executive share options should be taxed as income rather than capital gains.

(Cohen, 1995)

In the midst of this debate the Prime Minister, John Major, shifted his position from that of supporting self-regulation and non intervention to signalling the potential for legislation to address a matter of escalating public concern and growing political interest. At no other time has corporate governance faced so many pressures:

* the emergence of private companies
* the scale and complexity of corporate groups
* the significance of institutional investors
* the hostile activities of predators
* the criminalization of insider dealing
* litigation against directors
* calls for more checks and balances at board level
* changes in the world of international auditing
* newly corporatized and privatized corporate entities
* rethinking the nature of the company.

(Tricker, 1994b p4-6)

all of which will have an impact upon the definition and practice of corporate governance throughout the private sector.

This chapter has explored the private sector literature, in particular its origins, ideas and theories about the subject and thus its meaning to-day. The model of corporate governance developed by Tricker is particularly

helpful, both as a framework with which to explore the literature further, and as a basis for comparison with and the study of the boards of District Health Authorities. The remainder of the chapter concerns the role of directors/the board and of board effectiveness. The chapter concludes by reflecting upon the flawed nature of the practise of corporate governance in the UK and the response of the City, Government and public to such events. Before moving on to applying the insights gained from the literature to the theoretical and practical pursuit of research it is perhaps appropriate to pause, reflect and consider the themes to have emerged from a rich and comprehensive literature. It is to this that we now turn.

- Chapter 6 -

The Literature V: Making Sense Of It All

6.1 Themes and Variation

The chapters reviewing the literature have focused upon a diverse but interrelated range of topics, all of which are essential to a proper understanding of corporate governance in the NHS to-day. Chapter 2 dealt with the major political, institutional, organisational and managerial changes in the NHS from 1979 to the present time. The picture to emerge from this is one of a sea change in the political and social climate within the UK, which changed the way Government viewed the appropriate size and scope of the public sector and introduced a range of measures to reform that which remained. The NHS was both the object of reform and, as a result of its experience, an important contributor to the development of the 'new public management'.

Chapter 3 examined both the genesis of Health Authorities and, more particularly, the role and contribution of the HA member. This literature is largely normative and - concerned with the individual attributes of members, their preparation and training, organisational structure and culture, and, officer-member relations - largely follows the contours of the framework established by Ham (1986b, p121).

Although Government has appeared to discourage attempts to evaluate the introduction of health service reform (Hunter, 1994) there have been some notable exceptions in the realms of the role and performance of Health Authorities and their members. Perhaps the most authoritative figure in the field of HA research being Ham whose work with, and analysis of, such bodies continues apace. The work undertaken by Ham and his colleagues tends towards small sample studies and in depth consultancy, each feeding and facilitating the other. In this regard he was the first to publish any view of post reform Health Authorities, which reflected both his earlier approach to and took account of the revised and enlarged role of DHAs.

In *Purchasing with Authority : The New Role of DHAs* he explored the emergence of the purchaser role and also the contribution of the Chairman, Executive and Non-Executive members (Ham & Mathews, 1991). The paper touches upon issues of Non-Executive member quality and recruitment (ibid, p5) and in so doing echoes earlier concerns. Most attention, however, focuses upon the new purchaser role and how members undertake their task. They conclude, that the new Health Authorities "feel different [to] their predecessors" (ibid, p12) and later that:

> "the composition of authorities is leading to a more business like approach and it has been easier to develop a corporate way of working".
>
> (Ham, 1991 p22)

By contrast the Warwick team under the leadership of Pettigrew undertook a three year formal study of Health Authorities - *Authorities in the NHS* - funded by the National Health Service Training Authority (NHSTA) and the National Association of Health Authorities and Trusts (NAHAT) which focused:

> "on one particular aspect of this restructuring, namely the introduction of new style executive and non-executive members to lead the new authorities"
>
> (CCSC, 1991 p26)

The study was, however, concerned with *all* forms of Health Authorities and considered its topic at organisation, authority and member level in an effort to "discover and disseminate new empirical knowledge" (ibid, p26), to provide feedback and to identify the training and development needs of Executive and Non-Executive members. A detailed examination of the 12 practitioner reports[1], however, revealed little in the way of new thinking or analysis. Rather, the concerns - with the characteristics and qualities of members, their preparation and training, and, issues of structure and culture - are all, again, present. Although presented in a manner appropriate to current circumstance they offer only a limited advance upon orthodoxy. One exception is the relationship between executive members and the CEO and between all executives and the non-executives. In these areas the approach does depart from the conventional wisdom of the largely

adversarial officer-member relationship towards a more collegiate executive/non-executive axis.

Post reform research, reveals an agenda still preoccupied with the performance and impact of members albeit within a recast and redefined Health Authority framework. The two dominant figures, however, bring different histories and orientations to the work and thus some interesting contrasts. Ham offers a seasoned, narrowly focused and less formal approach. Pettigrew a less experienced[1], more widely focused and highly structured approach. The former is clearly accessible and direct, the latter dense, yet richer. Whatever differences in style and emphasis separate them, each is influential in terms of policy development and practitioner behaviour.

Chapter 4 explored the experience of governance in the NHS. In particular it considered notorious examples of the collapse of governance and the effect this had upon public and Parliamentary opinion. These examples, more than anything else, drew attention to the emergence of corporate governance in the NHS and its importance, limitations and the need to take it seriously. The publication of the Codes of Conduct and Accountability (DOH, 1993) can be seen as a direct consequences of these circumstances, if a somewhat partial view of corporate governance. These developments

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[1] The notion of less experience in this context is in terms of a history and reputation in the field of Health Authority research and NOT Health Service research *per.se*..

were themselves followed by (wider) public concern about the standards of personal conduct in public life. This led to the establishment of the Nolan Committee whose recommendations will also have an impact upon the exercise of corporate governance in Health Authorities.

Chapter 5 turned to the private sector literature to inform the proposed analysis. This is - now - a rich literature containing material which reflects the experience of much of the developed world. The chapter opens by defining corporate governance, before exploring stewardship and agency theories. By far the most significant contributor to the private sector literature is Tricker, upon whose work both the chapter and this study, draw heavily. His model of corporate governance is particularly helpful in offering a framework to enable the study of the topic and a construct within which the behaviour of individuals and boards can be placed and understood. The insights derived from his work were powerful influences upon: the research design for this study, developing a comparative understanding of the subject, identifying issues and themes, and, framing questions. The chapter also discusses the growth in the interest in corporate governance which derives from a series of scandals which rocked the private sector and from the subsequent publication of the Cadbury and Greenbury Report(s).

6.2 The Emerging Issues

The literature review has drawn upon a number of sources - NHS/public sector reform, the role and performance of the Health Authority member, the experience of corporate governance in the post reform NHS, and, private sector material on corporate governance - to inform the proposed study. A number of key points emerge from such an analysis:

* for largely ideological reasons there has been a sea change in public sector management; a paradigm shift which has seen the adoption of markets as the most appropriate manner of allocating scarce resources and which has had a major impact upon managerial roles, attitudes and behaviour

* there is an established interest in and dissatisfaction with the role and performance of HA members

* recent reform of the NHS has consequently witnessed a shift away from large, lay and quasi representative District Health Authorities to smaller more professionally managed "business like" bodies

* members and officers have both been subject to convergence in the sense that members (now non-executive directors) are increasingly concerned with corporate management, and officers (executive directors) with matters of governance

* the model upon which these reforms are based is an analogue of the company board from the private sector 'market place'

* thus, the private sector literature - in particular the notion of corporate governance - provides a model or framework which increases our understanding and thus supports efforts to investigate these changes.

Any attempt to explore or evaluate corporate governance in the post reform NHS must start from this understanding and, in particular, focus upon the extent to which things are both different and better. As has been observed "the challenge is to produce a better system of governance than in the past, against a changed and untested context" (Fitzgerald & Pettigrew, 1991 p34).

Before turning our attention to an identification of the research questions it is perhaps worthwhile reflecting upon the West Midlands RHA, Wessex RHA, South Birmingham HA and London Ambulance Service scandals - see **Table 6.1** These examples of 'systems failure' suggest the importance of clarity of organisational purpose and the dangers of it being displaced by a single, perhaps critical issue, which comes to occupy and distract the board. Also important is the presence of a dominant and/or plausible figure and the role they play in provoking, or failing to act effectively, in a crisis - by the commitment they have to a particular issue almost to the exclusion of all else. In almost all cases rules were overtly broken or key players behaved in a manner at odds with the ethical expectations of the organisation's stake holders. In all cases the structure of the organisation or the board was an important contributory factor. Most importantly there was a failure to adequately supervise and to take appropriate and timely corrective action when difficulties were eventually acknowledged.

Table 6.1 - A Comparison of Critical Factors in NHS Corporate Governance 'Scandals'				
Critical Dimension	**Public Accounts Committee**			**Health Committee**
	West Midflands RHA	**Wessex RHA**	**South Birmingham Health Authority**	**London Ambulance Service**
Clarity of organisational purpose			obscured	
Strong (issue specific) vision	dominated	dominated		dominated
Dominant/plausible central figure	dominant	dominant	plausible	dominant
Strength of purpose	yes	yes	no	yes
Rules broken	yes	yes	?	yes
Unethical behaviour/dimension	yes	yes	yes	yes ?
Poor/misleading information	yes	yes	yes	yes
Inadequate structure	no audit committee	no audit committee	matrix structure	confused
Failure to supervise	yes	yes	yes	yes (x2)
Speed of recognition	slow	slow	denial	slow
Inadequate financial control		yes	yes	yes
Failure to comply with rules	yes	yes		yes
Inadequate stewardship	yes	yes	yes	yes
Failure to provide VFM		yes	yes	yes

In the face of these circumstances one is forced to ask:

* where were the boards of directors ?
* where were the audit committees ?
* where were the lawyers ?
* where were the auditors ?
* where were the regulators ?

(Monks & Minow, 1995 p 456)

6.3 The Research Questions

What then are the as yet unanswered questions, the issues that deserve investigation ? It seems probable that such questions can be accommodated within and derived from the framework used in the analysis of the core literature, thus:

7.3.1 The Individual Attributes of Members

* Is there clarity about director selection and the basis of their appointment ?
* Do directors represent given interests ?
* Given continuity or change in the appointment of directors, what impact does this have for Health Authorities ?
* Are there issues of succession planning ?
* Are non-executive directors clear about their role ?
* Do non-executives directors contribute valued skills to the board ?
* Can directors make the time commitment required of them ?
* Are directors concerned with broad policy or operational issues ?

7.3.2 The Preparation and Training of Members

* What training and preparation can optimise the performance of directors ?

* How can specific knowledge gaps be addressed ?

7.3.3 The Organisation Structure

* How is the frequency, timing, length and format of Health Authority meetings structured and by whom ?

* How and who formulates the agenda for Health Authority meetings ?

* On what basis is information provided to support the work of directors ?

7.3.4 The Organisation Culture

* Is there continuity or change in the culture of District Health Authorities ?

* Do (private sector) non-executives influence the present culture ?

* What are directors attitudes to reform ?

* How do Health Authorities define markets, market strategies and collaboration Is there a shared corporate identity ?

* Is there a concern to operate within an overt ethical and legal framework ?

* Do directors work as a team of which executives are an integral part ?

* Do all directors contribute ?

* Is there shared knowledge and data between executives and non-executives ?

* Are there effective relationships ?

* Is there an open and critical group culture within District Health Authorities ?

7.3.5 The Power Structure

* How do District Health Authorities define and allocate director roles ?

* Do executives and non-executives work together ?

* Do executives behave functionally, corporately or in both ways ?

* Do executives hold the balance of power in decision making ?

* Do non-executives hold executives to account ?

* What evidence of this is there under conditions of crisis ?

* Do District Health Authorities tolerate dissent in the conduct of their business ?

Whilst all of these questions are both interesting and valid, some focusing must take place and priorities be determined.

The individual attributes of directors, together with their preparation and training are areas which have been given particular attention in contemporary investigation. By contrast much less attention has being paid to the role of executive directors and their relationship to and work with Non-Executive directors. Given the thrust of the reforms this is a significant omission. This axis is critically important to the success or otherwise of the present reforms given the "radically different conception of the relationship between policy makers and the executive" (Ashburner & Cairncross, 1991 p3).

In summary, any consideration of the present reforms has to distinguish between the rhetoric of the White Paper and the reality in the boardroom. The reforms will only

succeed - in terms of governance - if the wished for changes within District Health Authorities take place. This will depended, crucially, upon the activities of the newly created Executive and Non-Executive directors. The research questions are therefore:

1. To what extent do issues of **tenure, gender, age and ethnicity** influence the composition and orientation of District Health Authority boards ?

2. To what extent can behaviours consistent with Tricker's categories of:
   * **direction,**
   * **executive management,**
   * **supervision,** and,
   * **accountability**

   be identified and thus the existence of corporate governance be demonstrated in District Health Authority boards ?

3. To what extent are such patterns consistent with:
   * the *Working for Patients* reforms ?
   * subsequent Codes of Conduct and Accountability ?
   * the recommendations of the Nolan Committee ?

4. What **implications** do the findings have **for** the **development** of District Health Authority directors ?

5. What **implications** do the findings have for **the further development of corporate governance** in the NHS and throughout the public sector ?

Although these are issues concerned with process rather than outcome "we have to assume positive connections between what is done by NHS personnel and benefits to the patients" (Haywood 1983, p3). It is to a consideration of this and other questions of methods that we now turn.

1. Authorities in the NHS

Pettigrew A, Ferlie E, FitzGerald L & Wensley R (1991)
Authorities in the NHS: Research for Action - Paper 1
The Leadership Role of the New Health Authorities: An Agenda for Research and Development.
Bristol, NHSTA

FitzGerald L & Pettigrew A (1991)
Authorities in the NHS: Research for Action - Paper 2
Boards in Action: Some Implications for Health Authorities
Bristol, NHSTA

Ashburner L & Cairncross L (1991)
Authorities in the NHS: Research for Action - Paper 3
1990/91 Health Authorities in Formation
Bristol, NHSTA

Cairncross L, Ashburner L & Pettigrew A (1991)
Authorities in the NHS: Research for Action - Paper 4
Membership and Learning Needs
Bristol, NHSTA

Ashburner L & Cairncross L (1992)
Authorities in the NHS: Research for Action - Paper 5
Members: Attitudes and Expectations
Bristol, NHSTA

Cairncross L & Ashburner L (1992)
Authorities in the NHS: Research for Action - Paper 6
NHS Trust Boards: The First Wave - The First Year
Bristol, NHSTA

Ferlie E, Fitzgerald L & Ashburner L (1992)
Authorities in the NHS: Research for Action - Paper 7
The Challenge of Purchasing
Bristol, NHSTA

Ashburner L (1993)
Authorities in the NHS: Research for Action - Paper 8
FHSAs: Authorities in Transition
Bristol, NHSTA

Fitzgerald L (1993)
Authorities in the NHS: Research for Action - Paper 9
Director Development and Team Building in Health Authorities and Trust Boards
Bristol, NHSTA

Ferlie E, Ashburner L & Fitzgerald L (1993)
Authorities in the NHS: Research for Action - Paper 10
Board Teams: Roles and Relationships
Bristol, NHSTA

Ashburner L, Ferlie E & Fitzgerald L (1993)
Authorities in the NHS: Research for Action - Paper 11
Boards and Authorities in Action
Bristol, NHSTA

Ashburner L, Ferlie E & Fitzgerald L (1993)
Authorities in the NHS: Research for Action - Paper 12
Leadership by Boards in Healthcare
Bristol, NHSTA

- Chapter 7 -

Research Design and Methodology

7.1 Introduction

The aim of the research is to explore the impact upon governance of structural and constitutional change in English District Health Authorities, consequent upon the NHS & Community Care Act 1990. Central to this are a series of questions, the majority of which are embedded in the role of Executive directors and their relationship to and work with Non-Executive directors. The literature has been consulted in an effort to refine these questions. This chapter, however, will consider the philosophical and organisational **influences upon research design.** The following chapter will then go on to address the **research methods** employed.

7.2 Issues and Choices in Research Design

7.2.1 Theoretical and Policy Research. It will be important to recognise from the outset the distinction drawn by Scott & Shore (1979, p224-239) between knowledge for understanding and knowledge for action; more simply put, as theoretical and policy research. The former is concerned

with causal processes and explanation, usually within the framework of a single scientific discipline and with an intended audience of academic social scientists in the main. Policy research, by contrast, covers a wide field (and may include theoretical or descriptive perspectives) which maps out an issue or topic and includes how policy is working, including formal evaluation. In addition, policy research tends towards multi methods/disciplines and is normally reported in 'plain english' for consumption by a wider audience of policy makers, practitioners and pressure groups etc..

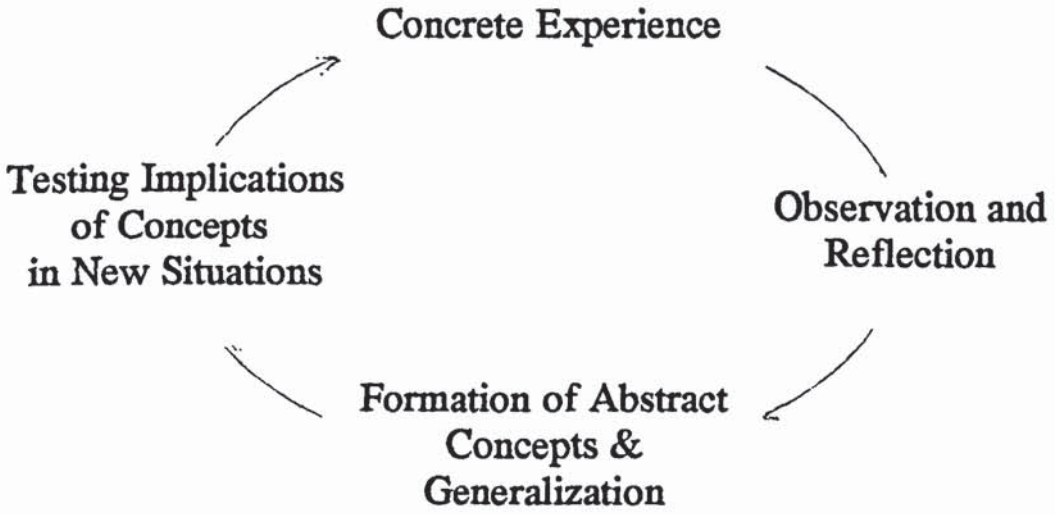
A good deal of policy research addresses respondents and informants as role holders rather than as private individuals. Frequently the concern is "did X happen or not ?", with the bulk of such studies being "concerned with defining, describing or measuring X with a view to concluding that it did or did not happen... and may even constitute the test of a thesis" (Hakim, 1987 p6). Hakim identifies another major difference in respect of the quantitative analysis of survey and other data:

> "Theoretical research (and academic writing more generally) is orientated towards reporting statistically significant results, with lesser emphasis on the size or strength of any association between the social factors studied. In contrast, policy research requires robust results on association, the impact of any given factor and so forth."
>
> (ibid, p6)

It is important, therefore, not to confuse statistical significance - itself, in part, a function of sample size - with the substantive or practical importance of research results which are a matter for judgement and not simply mathematics (Morrison & Henkel 1970; McCloskey 1985).

7.2.2 The Role and Contribution of Theory. Both theoretical and policy research are underpinned and separated by differing assumptions. This can be further understood by a consideration of the role and contribution of theory to both research design and methods. In a general sense human beings engage in a 'theory dependent' existence and construct, evaluate and reconstruct expectations and explanations in an attempt to understand and relate to the events of which they are a part (Law & Lodge, 1984 p125). This view is perhaps best known and most eloquently described in Kolb's experiential learning cycles which offers a model of human learning (Kolb *et.al.*, 1979) - see **Fig 7.1.** Kidder & Judd (1986, p5), however, separate science from what might otherwise be regarded as common sense, by claiming that 'science' entails a deliberate and rigorous search for bias and invalidity. Although science adopts theories, hypotheses and concepts to test and thus demonstrate causal relationships, it is the manner in which science proceeds that separates it from common sense. In their different ways both seek explanation and certainty. As Gill & Johnson (1991, p27) observe:

Fig 7.1
Kolb's Experiential Learning Cycle



Source: Kolb, Rubin & McIntyre, 1979 p38

> "it is evident that if we have the expectation that by doing A, B will happen, then by manipulating the occurrence of A we can begin to predict and influence the occurrence of B. In other words, theory is clearly enmeshed in practice since explanation enables prediction which in turn enables control."

7.2.3 Deduction and Induction. To more fully understand the role and contribution of theory, it is necessary to consider the intellectual processes from which theories are themselves derived i.e. deduction and induction.

"A deductive research method entails the development of a conceptual and theoretical structure prior to its testing through experimental observation" (Gill & Johnson, p28). This corresponds to the left hand side of Kolb's experiential learning cycle and involves the following steps.

1. The researcher selects the concepts which represent important aspects of the problem to be investigated.

2. The concepts are defined in an operational manner which facilitates their observation and thus their empirical occurrences. Standardizing the recording of occurrences results in a reliable measure of the concept.

3. The process of operationalization thus enables clear instructions about what and how to observe. This permits the testing of hypotheses and theories by confronting them with empirical data which have been collected and corroborated.

4. Finally, the assertions of the hypotheses are compared with the 'facts' collected by observation. If proven, the theory is assumed to have established a valid or 'covering law' explanation. In practice, however, this is expressed in terms of the statistical degree to which the law pertains across all circumstances.

Such an approach is not without difficulty, for as the 'Hume problem of induction' asserts, no amount of assertion on the basis of a finite number of observations can guarantee a theory for all time and circumstances. It was precisely this dilemma which led Popper (1967; 1972a; 1972b) to reject "verification" in favour of "falsification". Popper argued that while theories can never be conclusively proven, they can be falsified by only one contradictory observation. Thus Popper's contribution reinforced empirical testing, shifted the emphasis to falsification and offered a schema within which science could advance by discarding falsified propositions.

Conversely an inductive orientation involves almost the opposite of deduction "as it involves moving from the 'plane' of observation of the empirical world to the construction of explanations and theories about what has been observed" (Gill & Johnson, 1991 p33). This corresponds to the right hand side of Kolb's experiential learning cycle and observes the following rationale.

1. Human action has an integral logic of its own, a factor which distinguishes it from the subject matter of the natural sciences which have no subjective comprehension of its own behaviour.

2. Human action is seen as purposive and becomes intelligible only when one gains access to that subjective dimension.

3. It follows that the analyses embraced by deduction, in which an external frame of reference is imposed upon the behaviour of the phenomena, are inappropriate.

In contrast to the deductive tradition, in which a conceptual and theoretical structure is developed prior to empirical research, theory is the outcome of induction. This is relatively worthless, however, unless grounded in observation and experience (Glaser & Strauss, 1967).

This rejection of the stimulus-response model implies,

(a) stimulus -> experience and interpretation -> response

(b) interpretation and meaning -> action

in which the actors' subjectivity is taken as the "intervening variable" in (a) or accorded formative or "creative power" in (b) (Gill & Johnson, 1991 p34-35). The subjectivity of actors is critical in so far as:

> "Whether about generalities or particulars, man thinks always by the same methods. He observes, discriminates, generalises, classifies, looks for causes, traces analogies and makes hypotheses."
>
> (Ryle, 1975 p20)

This is consistent with notions of "man as scientist" (Shaw, 1980) and with the "social construction of reality" (Berger & Luckman, 1967). From the viewpoint of the *researcher*, it is equally possible to address the data in this way - to retrospectively develop a view or theory as to its meaning - i.e. grounded theory (Glaser & Strauss, 1967). Indeed the construction of scientific knowledge:

> "... can be thought of as a 'world making' process. Reality is not just interpreted but manufactured."
>
> (Knor-Cetina & Mulkay, 1983)

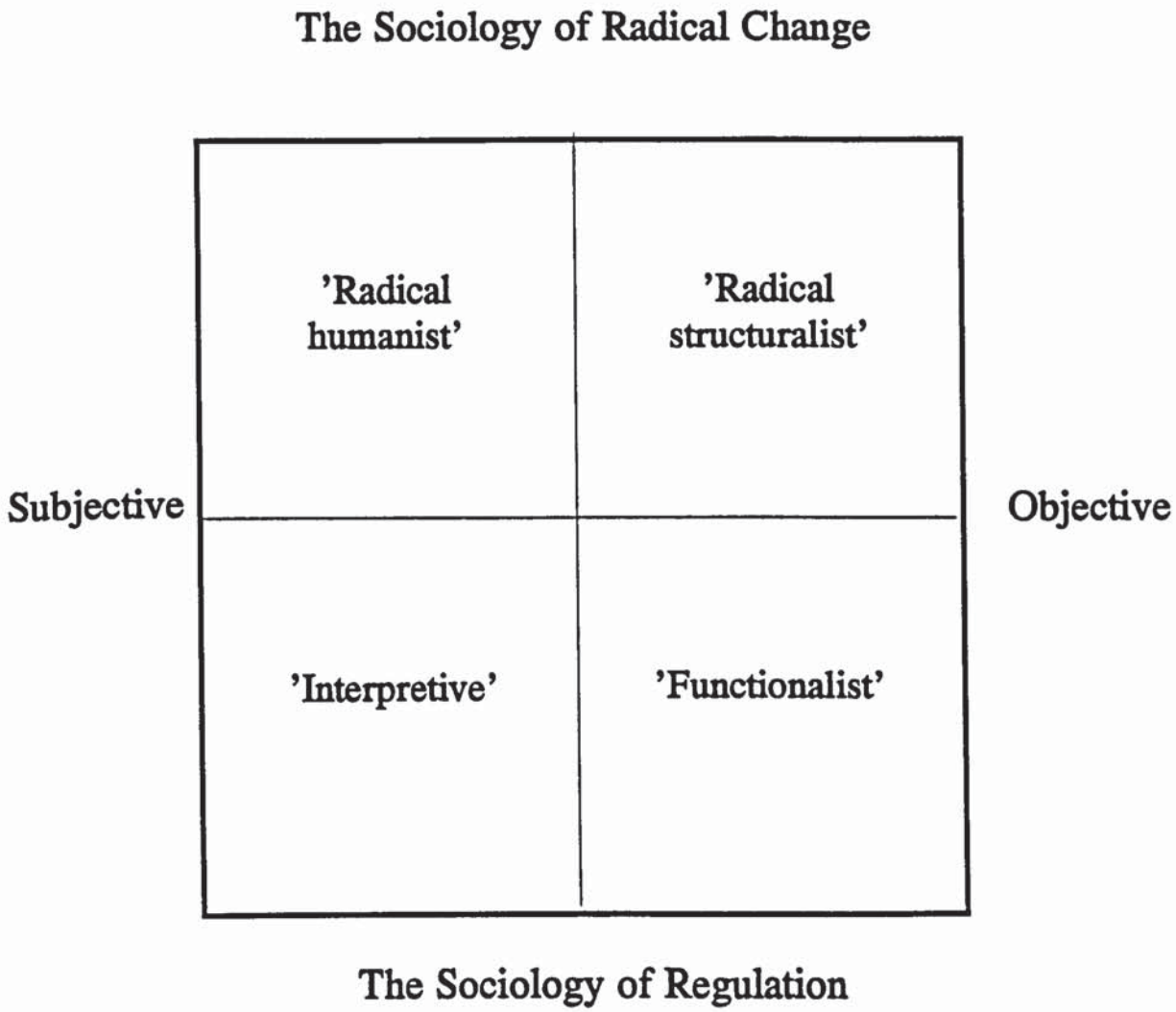
Such an orientation creates serious objections to the positivist outlook, particularly the tendency of the latter to treat (unsympathetically) the subjects as objects. The methodological consequences being to avoid highly structured or deductive approaches which deny or ignore the central importance of the actors' subjectivity. Perhaps one of the best known and most powerful contributions to a consideration of such matters was that of Burrell & Morgan (1979) who postulated a "nominalism - realism" ontology, an "anti-positivism - positivism" epistemology, a "voluntarism - determinism" human nature and an "idiographic - nomothetic" methodology. The latter, particularly, complements the above inductive - deductive distinction - see **Fig 7.2** and **Fig 7.3**

7.2.4 Positivism and Phenomenology. Easterby-Smith *et.al.* (1991) address the same polemic in terms of the philosophies of positivism and phenomenology. In the case of the former:

> "The key idea of positivism is that its properties should be measured through objective methods, rather than being inferred subjectively through sensation, reflection or intuition."
>
> (ibid, p22)

This contrasts with phenomenology, which is rooted in the assumption:

Fig 7.2
Four Paradigms for the Analysis of Social Theory



Source: Burrell & Morgan, 1977 p22

"... that reality is socially constructed rather than objectively determined. Hence the task of the social scientist should not be to gather facts and measure how often certain patterns occur, but to appreciate the different constructions and meanings that people place upon their experience. One should therefore try to understand and explain why people have different experiences, rather than search for external causes and fundamental laws to explain their behaviour. Human action arises from the sense that people make of different situations, rather than as a direct response from external stimuli."

(ibid, p24)

Fig 7.3
A Comparison of Nomothetic and Idiographic Methods

Nomothetic Emphasis	Idiographic Emphasis
1. Deduction.	1. Induction.
2. Explanation via analysis of causal relationships and explanation by covering laws.	2. Explanation of subjective meaning systems and explanation by understanding.
3. Generation and use of quantitative data.	3. Generation and use of qualitative data.
4. Use of various controls, physical or statistical, to allow the testing of hypo-theses.	4. Commitment to research in everyday settings to allow access to, and minimize reactivity among, subjects.
5. Highly structured research methodology to ensure replicability of 1,2, 3 and 4.	5. Minimum structure to ensure 2, 3 and 4 - and as a result 1.
Lab expt->Quasi expt->Surveys->Action Research->Ethnography	

Source: Gill & Johnson, 1991 p36

Easterby-Smith *et.al.* not only clearly differentiate these two traditions, but identify their respective manifestations in terms of research design - see **Fig 7.4**

Fig 7.4
Key Choices in Research Design

Researcher is independent	v	Researcher is involved
Large samples	v	Small samples
Testing theories	v	Generating theories
Experimental design	v	Generating theories
Verification	v	Falsification

Source: Easterby-Smith *et.al.*, 1991 p33

Although such a comparison is helpful, the contrast of verification and falsification, as presented, is a misleading one. Whilst they clearly represent different viewpoints (Popper, 1967; 1972a; 1972b), they are none-the-less only different sides of the same coin. For whether a theory is proven or disproven, this is only an issue in the deductive/positivist tradition.

7.2.5 Types of Questions. Another important consideration in terms of research design are the types of question(s) being posed. If the questions are of the 'what', 'who' or 'where' variety they "are likely to favour survey strategies or the analysis of archival records" (Yin, 1988 p18). Such approaches are particularly useful in establishing prevalence or predictive outcome.

Alternatively, if the questions are 'how' or 'why', a more explanatory orientation is evident and "likely to lead to the use of case studies" (ibid, p18).

7.2.6 The Study of Organisation. The formulation of such questions in the conduct of management/organisation research assumes, however, clarity as to what constitutes management and also having a clear view of how best to approach the study of organisations. One approach to both issues is the model for the analysis of social theory developed by Burrell & Morgan (1979, p22) in which they offer two dimensions and four paradigms - see **Fig 7.2.** The authors contend that the functionalist paradigm is the "dominant framework" for the study of organisations and is characterised by the need to explain "the status quo, social order, consensus, social integration, solidarity, need satisfaction and actuality" (ibid, p26). The characteristic approach in the functional paradigm is sociological positivism which draws heavily upon the mechanical and/or biological metaphor (Morgan, 1986). The complementary - in terms of "social regulation" - interpretive paradigm is:

> "... informed by a concern to understand the world as it is, to understand the world at the level of subjective experience. It seeks explanation within the realm of individual consciousness and subjectivity, within the frame of reference of the participant as opposed to the observer of action."
>
> (Burrell & Morgan, 1979 p28)

The characteristic approach in the interpretative paradigm is idiographic, one which sees the world as "an emergent social process" (ibid, p28). The remaining paradigms, radical humanism and radical structuralism - concerned with anarchistic individualism and Marxist theory respectively - are not immediately helpful in informing the management of contemporary health care in the UK. Overall, however, the vertical plane may suggest a tension between order and conflict. The functional theories are clearly concerned with explaining the status quo, the conflict theories concerned with understanding "the process and nature of deep-seated structural change" (ibid, p14).

The functionalist-interpretative paradigms also provide a convenient macro-micro continuum. This is a distinction made by Van De Ven & Astley (1981, p429) who contrast these perspectives in the following terms,

> "... the micro level includes individual organisations and the people or positions within them, while the macro level examines populations, networks, and communities of organisations."

Indeed, it seems self evident that the comprehensive study of organisations should reflect both perspectives.

The approach taken to organisational investigation must also, of necessity, be predicated upon an ontological assumption. The deterministic view of organisational behaviour (OB) is that of an external concrete reality, which, in contrast to the voluntaristic perspective, sees

such matters as subjective and the product of internal construction (Van De Ven & Astley, 1981).The reality, however, is likely to be between these two poles:

> "Organisational roles and structure provide a framework for action, but these are constantly susceptible to modification as people succeed in imposing their own definitions of reality upon the situation."
>
> (Salaman, 1980)

Such a view implies a process of change and adjustment which, at the strategic level, follows either the "systematic conflict" or "strategic choice/entrepreneurial" framework(s) (Wilson, 1992). Both view the organisation as a social system with the former characterised by conflict and tension between individual/departments/organisations with the impetus for change arising from unresolved conflict. This contrasts with the strategic choice/ entrepreneurial perspective where the managers task "is to scan the environment and import the most relevant solutions" (ibid, p2). As Wilson goes on to observe:

> "... managers build up a set of beliefs, norms and cause-effect maps which represent a consistent pattern or design track for managing the organisation in its wider environment."
>
> (ibid, p86)

It follows that change can arise for any number of reasons and from different quarters (ibid, 128) but is then subject to both interpretation and refinement in the process of implementation.

7.3 Discussion

What conclusions can be drawn from a consideration of the above factors and how they influence research design ? Clearly the nature of this study is such as to locate it within the field of "policy" research. As such the study will be concerned to identify the existence of corporate governance and how it is (or is not) working based upon data largely provided by role holders. In pursuit of this, theory will be deductively evoked to operationalize the concept of corporate governance and thus test its existence and prevalence. Subsequent investigation will examine the experience of corporate governance together with a detailed consideration of progress in specific settings - a process which should result in the development of inductive theory.

Such an approach appears at first to embrace two mutually exclusive positions ? This, however, is only the case if one views the nomothetic/positivistic and idiographic/phenomenological position(s) in 'either/or' terms. If one conceives of them not as opposite ends of a continuum, but, rather, as occurring at different points in a circle, then each perspective is legitimate and likely to yield different yet equally valid data. It follows that otherwise 'different' methods can be accommodated within a single design. The nomothetic/positivistic survey technique being well suited to determining existence/ prevalence and the idiographic/phenomenological case studies to developing

a more contextual understanding. These approaches being entirely consistent with what/who/where and how/why questions respectively. Finally, a design configuration of this type facilitates organisational analysis at both the micro and macro levels and thus comprehensively illuminates corporate governance at the level of the institution (NHS) and in terms of individual reality.

7.4 Conclusion

This chapter has sought to explore the influences upon research design and, in particular, explored the nature of the research, the type of questions to be pursued and thus the most appropriate practical and intellectual means of doing so. An argument has been advanced which suggests the need to systematically collect data from a large number of directors - which lends itself to a postal survey - and the need to explore further such behaviour and experience in its natural environment. This latter requirement lends itself to the case study method. Such an approach, involving as it does survey, interview and documentary data - over time - will yield sound data, susceptible to analysis from which robust conclusions can be drawn.

- Chapter 8 -

Research Methods

8.1 Introduction.

The previous chapter explored in some detail the influences upon research design and concluded by advancing the case for a 'mixed' methodology. This chapter will take this further. In particular it will set out the approach taken in conducting the postal survey and in undertaking the case studies.

8.2 The Postal Survey.

Gill & Johnson (1991, p75) distinguish between "analytic" and "descriptive" approaches to survey research. This survey will fall between these two poles in that:

> "Data construction takes the informants' concepts, cleans them of the looseness and fuzziness that characterise everyday knowledge, and refines them into standard forms so that the items of knowledge of the many survey informants may be combined to present a single picture of the social world... "
>
> (Bateson 1984, p24)

In short, the literature provided the basis for the development of appropriate questions and areas of investigation for the postal survey. The resultant data

were analyzed in terms of frequencies and statistical significance - an 'analytic' dimension. These same data were also considered thematically - a 'descriptive' dimension - see Chapters 10-14.

The postal survey was selected as the best means of exploring this particular social world because of the **advantages** it offered in respect of:

* lower cost
* reduction in biasing error
* greater anonymity
* considered answers and consultation
* accessibility

(Nachmias & Nachmias, 1992 p216)

This is not to deny, however, the **disadvantages** of the mailed questionnaire:

* requires simple questions
* there is no opportunity for probing
* there is no control over who fills out the questionnaire
* low response rate

(ibid, p216)

but, on this occasion, the balance of advantage is considered to favour such an approach. In addition, good survey administration can overcome or minimise some of the disadvantages

The **sample** was identified as all the directors of District Health Authorities (DHAs) within three English Regional Health Authorities (RHAs). The RHAs in question

represented one of the largest (17 DHAs), one of the smallest (5 DHAs) and one in the mid range (11 DHAs). In each District Health Authority the full complement of five Executive and six Non-Executive Directors were surveyed to gather biographical, attitudinal and organisational data. The number of directors surveyed was 332 of which 247 returned completed questionnaires. MORI (1993) suggest that a group of 200 respondents will provide a sampling tolerance of ± 7.0% with 95% confidence. Although such a sample provides a perfectly acceptable level of statistical reliability to double the level of precision would require a sample four times as great i.e. 800. A lone part-time researcher must inevitably make a trade off between statistical reliability and time, cost and complexity.

Turning now to practical considerations - and returning to two of the disadvantages of the mailed questionnaire - it was important to pay particular attention to the **construction and format of the questions**, to facilitate ease of use and thus influence the response rate. Central to any questionnaire is the lucidity and adequacy of the questions posed. Gill & Johnson (1991, p85) advance the case that focus, phraseology, form of response and sequencing are critical to the formulation of questions. In short, the extent to which:

* the questions posed address fully the research problem

* the questions are intelligible to respondents

* the data elicited is in a form which permits ready analysis e.g. pre-coded v open ended, and,

* that questions follow a logical or considered path.

A final and important consideration was the **ethical framework** within which the study was conducted. The importance of which is increasingly reflected in the need to formally consider e.g. questions of privacy, consent, covert methods and reporting conventions (Homan, 1991). The particular requirements of management/employee surveys led Reeves & Harper (1981) to set out the following as the minimum requirements:

* The researcher should consult with all interested parties prior to embarking upon fieldwork and proceed only on the basis of consent.

* The manner and timing of the dissemination of results needs to be agreed.

* The purpose of a survey should be made explicit to enable informed participation.

* Any particular circumstances likely to affect the interpretation of the results should be clearly reported.

Whilst the ethical approach in this study cannot be as comprehensive as that advocated by Homan or approached in quite the same way as that suggested by Reeves & Harper, strict ethical standards were observed. The anonymity of respondents and their organisations was respected and the manner of reporting acknowledges this obligation.

8.3 Survey Administration and the Response Rate

8.3.1 Background Much has been written on the topic of survey response rates and their management (e.g. Dillman, 1978; Fowler, 1984; de Vaus, 1991; Rea & Parker, 1992), including the notion of exchange theory from social psychology (Thibaut & Kelly, 1959; Blau, 1964). This postulates that people will find the provision of data rewarding and that such rewards outweigh any costs; both within a climate of trust (Jankowicz, 1991 p223). Whilst such an approach may be important in shaping the environment in which a study is conducted, other more practical steps can be taken. Nachmias & Nachmias (1992, p217-223) reinforce the importance of sponsorship, inducement to respond, questionnaire format, mailing and return arrangements, covering letter and the selection of respondents. Much of best practice in questionnaire construction and survey implementation has come to be incorporated in the Total Design Method (TDM) (Dillman, 1983), a philosophy reflected throughout this study. The efficacy of such measures was tested in a pilot study designed to evaluate the data collection instruments, procedures and data analysis (see Chapter 9).

8.3.2 General Approach In both surveys - the pilot study and the main survey - questionnaires were sent out to the respective samples. The question topics were informed by the literature review, phrased unambiguously and set out in a logical sequence. The covering letter explained the

purpose of the investigation, invited respondents to return their questionnaires - which contained completion guidance - in the SAE provided.

8.3.3 The Pilot Study All Executive and Non-Executive directors of the District Health Authorities in a single RHA[1] were invited to complete a postal questionnaire - see Appendix 1 - during the course of July, 1993. Of the 63 directors then in post 49 returned a completed questionnaire which represented a response rate of 77.8% This was achieved from an initial mailing and from a single written reminder.

8.3.4 The Postal Survey All Executive and Non-Executive directors of the District Health Authorities within three English RHAs were invited to complete a postal questionnaire between November 1993 and January 1994 - see **Appendix 2**. Of the 332 directors in post, 247 returned a completed questionnaire which represented a response rate of 74.4% This was achieved from an initial mailing and from two written reminders - see **Fig 8.1**

Although there was some variation in response between the three Regions, the percentage response in Oxford and Trent was broadly comparable, the response in the West

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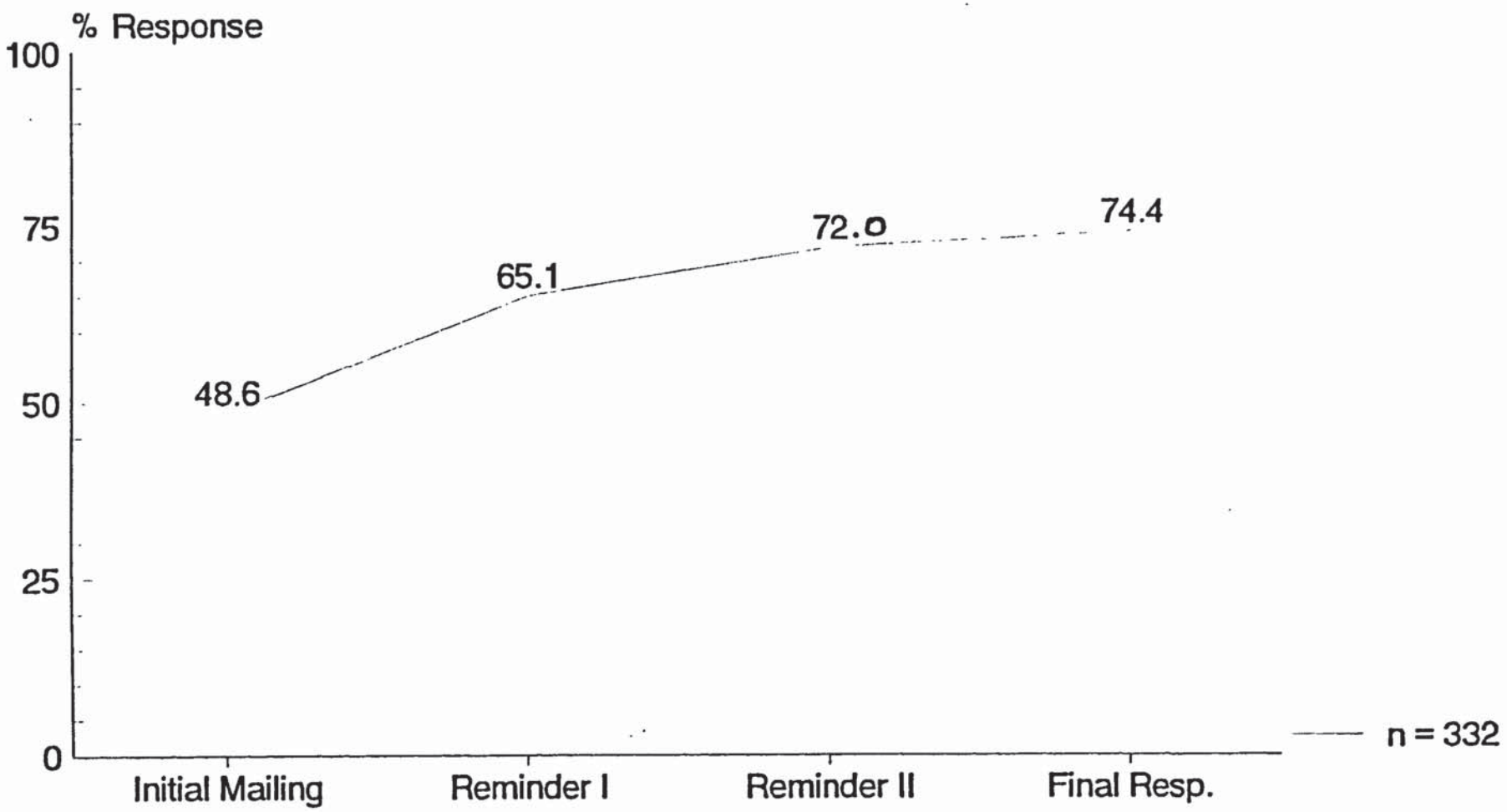
[1] This pre survey study was undertaken to pilot the questionnaire and to test both the procedures and the analysis. The sample was, therefore, never intended to be representative.

Fig 8.1
Postal Survey – Response Rate



Midlands somewhat higher - see Table 8.1. This latter phenomenon is thought, perhaps, to be due to the influence upon respondents of either the reputation of the Business School in its regional context and/or the effects upon "local" awareness of the much publicised governance difficulties within the West Midlands Regional Health Authority itself.

Table 8.1
Main Postal Survey
Sample and Response Actuals by NHS Region

		Oxford		Trent		West Midlands	
Role	**No ID**	**Samp**	**Resp**	**Samp**	**Resp**	**Samp**	**Resp**
Chair	1	5	2	11	6	17	15
NEDs	4	25	13	55	39	81	57
CEOs	0	5	3	11	5	17	15
Excts	6	15	12	35	23	56	47
Totals	11	50	30	112	73	171	134
% RHA Response			60.0%		65.2%		78.4%

In any survey it is also important to consider non responders. In this regard, the response rate is significant only in the sense that "non-respondents are a biased group who disproportionately possess or lack some characteristics of relevance to the study such that their absence from the respondent sample means that the results as a whole are correspondingly biased" (Luck *et.al.*, 1988 p202). An examination of response by role, however, suggests that this is not the case with Chairs, Non-Executive directors and CEOs responding to a comparable

degree, whilst Executives responded at a slightly higher level - see Table 8.2. There is no obvious reason for this, but Directors of Public Health were somewhat more likely to respond than other Executives and this may have increased the net response of Executives *per se*.

Table 8.2
Main Postal Survey
Sample and Response Actuals by Respondent Role

	Role	Sample Size	Response Rate by Role	Proportion of all Respondents
1	Chair	33	24 (72.7%)	9.7%
2	NEDs	161	113 (70.2%)	45.6%
3	CEOs	33	24 (72.7%)	9.7%
4	Executives	105	87 (82.9%)	35.1%
Totals		332	247 (74.4%)	100 %

8.3.4 Reflections It is clear that the response rates in both the pilot and the main survey were of an acceptable order. This compares very favourably with the 8% response rate achieved by the Institute of Directors (IOD, 1990) and the 20% response rate "normally achieved" by Korn Ferry (Buchanan-Barrow, 1993). The high levels of response in this study are, probably, due to a mixture of careful questionnaire design, sound survey administration, two written reminders and - as Hoinville *et.al.* (1987, p133) identify in respect of "specialist groups" - the critical importance of the topic to respondents.

8.4 The Case Studies.

In general terms **field research** is defined as "the study of people acting in the natural course of their daily lives" in which "the fieldworker ventures into the worlds of others in order to learn first hand about how they live, how they talk and behave, and what captivates and distresses them (Emerson, 1983 p1). The essential condition being the collection of data in *natural settings*.

The use of the case study method as the means of conducting observational studies of managers, studies of managers managing and studies of managerial work is well established (Hakim, 1987; Bryman, 1989; Gill & Johnson, 1991; Allan & Skinner, 1991). Some single case designs have been very influential in this regard (e.g. Goldthorpe *et.al.*, 1969; Heclo & Wildavsky, 1981). Indeed the case method has played a significant part in the study of managerial elites (e.g. Spencer, 1983) and in studies of Health Authorities both generally (e.g. Ham, 1986b) and in their response to specific reforms (e.g. Harrison & Nutley, 1993). This then is the backdrop to and the context for the further consideration of the case study method.

As noted in the previous chapter Yin (1991, p17) argues that 'who', 'what' and 'where' questions are best addressed by means of the survey, 'how' and 'why' questions are better suited to the medium of the **case study**. Yin defines a case study as an empirical inquiry that:

* investigates a contemporary phenomenon within its real life context; when

* the boundaries between phenomenon and context are not clearly evident; and where

* multiple sources of evidence are used

(ibid, p23).

The **choice of case study sites** was influenced by the nature of the subject and by geographical/practical considerations. An ideal choice would have been to have had one case study site in each of the three RHAs surveyed but this would have imposed practical and resource difficulties for a single and part-time researcher. For these reasons the selection of all three sites from a single - and the most geographically accessible - RHA was favoured. That said, the three case sites 'represented' shire, urban and metropolitan settings and therefore the full range of environmental possibilities. The number of case sites chosen was, in part, to reflect setting and to provide for replication and comparison. A minimum of two would have been viable; three, however, provided somewhat richer data and recognised and addressed the potential for any one case collapsing.

Critics of the case study method have raised questions of **representativeness and generalizability** as the source of major weakness. Under the influence of the quantitative tradition these have come to mean typicality in the sense of a statistically reliable random sample, and, the ability

to extrapolate with statistical confidence, respectively. In case study research it is more appropriate to treat representativeness in terms of the qualitative logic for their selection than a quantitative logic of sampling from a population. Indeed Allan & Skinner (1991) cite examples of a site being selected on the basis of it being as favourable as possible to a position being advanced or in some way representing a typical, deviant or critical case. Alternatively, multiple sites permit either replication in differing settings or the ability to compare and contrast sites which may exhibit differences despite superficial similarity. Not withstanding this, confidence in the general significance and robustness of findings increases with the number of sites in which the research is conducted, although the largest single gain occurs when the number of sites increases from one to two (Sudman, 1976 p26). The point here is that typicality in the statistical sense is not a major concern for case study research. This is not to suggest that representativeness ceases to be an issue. On the contrary, where more than one case is used the issue of selection criteria and qualitative representativeness can be of considerable importance. The implication of this is that a similar logic needs to apply to generalizability. Whereas the survey approach depends on typicality of the sample for making valid statistical inferences, the case study approach depends upon the "cogency of the theoretical reasoning" for the validity of any logical inference (Mitchell, 1983 p207).

Also important in minimising the grounds for criticism are the issues of **validity and reliability**. These can be characterised as follows:

* Construct Validity - establishing correct operational measures for the concepts being studied.

* Internal Validity (for explanatory or causal studies descriptive or exploratory studies) - a casual relationship whereby certain conditions are shown to lead to other conditions, as distinguished from spurious relationships.

* External Validity - establishing the domain to which a study's findings can be generalized.

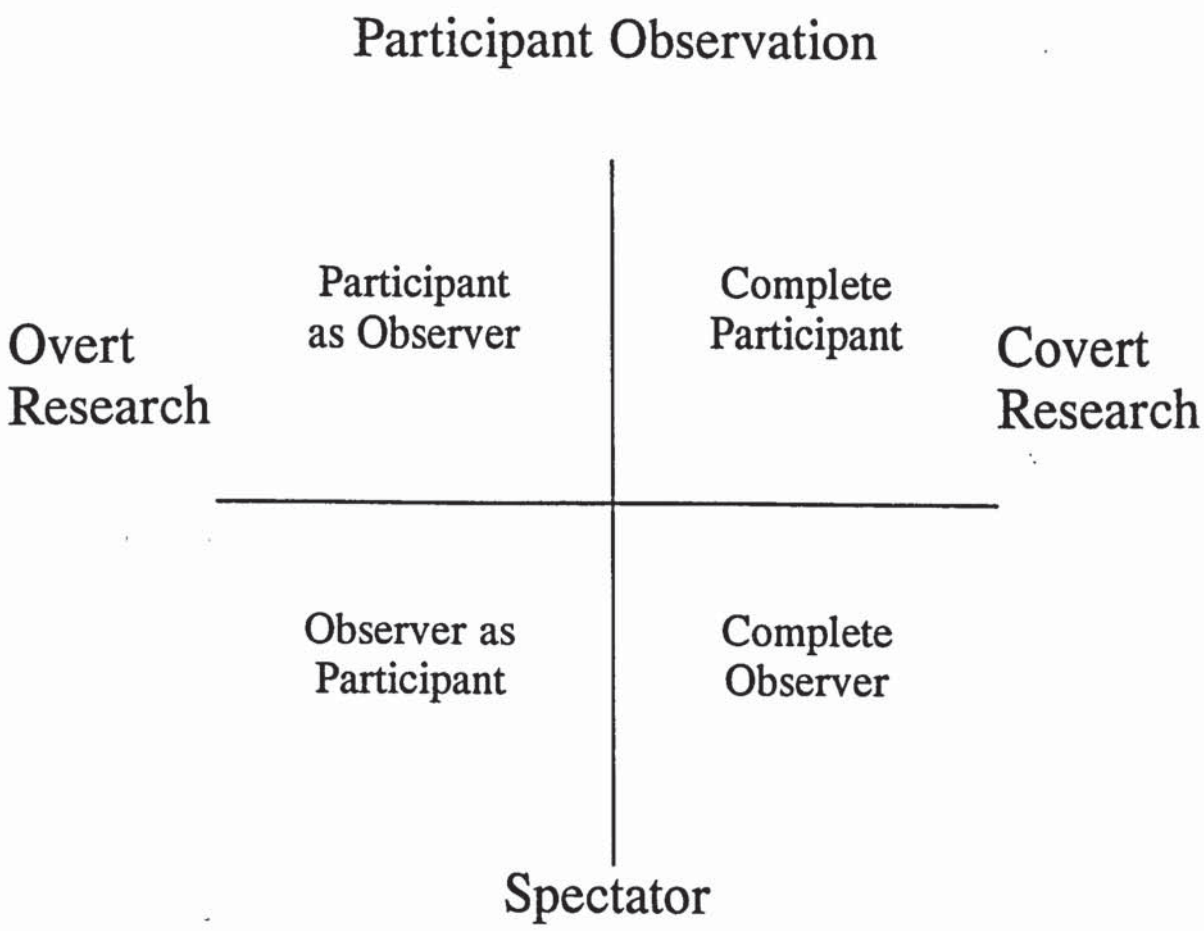
* Reliability - demonstrating that the operations of the study - such as the data collection procedures - can be repeated with the same results.

(Kidder, 1981 p7-8)

and can be addressed as set out in Table 8.3 below.

The essence of the case study,however, is to collect data and to study the phenomena in natural settings. This presupposes a number of possible roles for the observer. A useful conceptualization of such roles was provided by Gold (1958), subsequently modified by Junker (1960) - see **Fig 8.2**. Such a framework provides a range of alternative research roles - the most appropriate of which for this research being that of observer as participant. Easterby-Smith *et.al.* (1991, p96-100) offer a slightly different view again in terms of the researcher as employee, research as the explicit role, interrupted involvement of

Fig 8.2
The Role of the Researcher



Source: Junker (1960)

Table 8.3 Addressing Issues of Validity & Reliability		
Dimension of Validity	**Broad Strategy**	**Research Practice**
Construct Validity	* use multiple sources of evidence * establish chain of evidence * informant review of draft case report	* interview, obs and documentary sources * interview schedule & observation records * submission of draft report to each Chair
Internal Validity	* pattern matching * explanation building * time series analysis	) a concern in causal) and explanatory) studies only
External Validity	* use replication logic in multiple case studies	* three case studies - rely on analytical not statistical generalization
Reliability	* use case study protocol * case study data base	* clear prior relat-ionship between proposition and documentation * procedural consistency

Source: adapted from Yin, 1991 p41

observation alone. Whichever schema is considered, an important distinction is that of covert or overt observation. The former may be justified if it is believed that explicit observation will in some important fashion change events, or if there is difficulty gaining access. Covert observation does, however, raise many ethical issues. Easterby-Smith *et.al.* (1991, p101) suggest that the choice of role will be influenced by:

* the purpose of the research
* the cost of the research
* the extent to which access can be gained
* the extent to which the researcher would be comfortable in the role
* the amount of time the researcher has at his or her disposal.

The research role adopted throughout this study was both overt and non participant and therefore fell into the "observer as participant" quadrant of Junker's model.

It is axiomatic that an observer observes. A critical consideration is therefore **what should be observed.** Nachmias & Nachmias (1992, p200) propose four classes of non verbal and verbal behaviour:

* Nonverbal behaviour - "the body movements of the organism" (Ekman, 1957 p136) as valid indicators of social, political and psychological processes.
* Spatial behaviour - the attempts of individuals to structure the space around them. For example, people move toward, move away from, maintain closeness and maintain distance. The range, frequency and outcomes of such movements provide significant data.
* Extralinguistic behaviour - non content behaviours such as rate of speaking, loudness, tendency to interrupt and pronunciation peculiarities constitute a fruitful source of paralanguage data.
* Linguistic behaviour - the manifest content of speech and the structural characteristics of talking.

This is in some contrast to Yin (1991, p5) who identifies six sources of evidence *viz* documentation, archival records, interviews, direct observation, participant observation and physical artifacts. In each of the studies carried out in this research data were gathered by a number of means i.e. interview, observation and documentary sources.

8.4.1 Interviews In each case study site and at each visit the Chairman and CEO were interviewed, together with an Executive and a Non-Executive director on the first visit only - see Table 8.4 Initially planned to be of one hours duration, one interview took four hours (ending over lunch !). An interview schedule - based on the structure of the postal questionnaire - was developed (see Appendix 3) and followed loosely. Although all interviews covered the same issues some were pursued in depth, others in passing, depending upon the circumstances and the informant. A considerable amount of rich data was gathered from the eighteen interviews which were conducted over nearly 30 hours.

8.4.2 Direct Observation In each case study and at each visit the author sought to attend and observe the board in operation, both publicly and privately. The former tended to be public meetings of the District Health Authorities concerned, the latter, the private parts of the same meetings, pre meetings or board seminars - see Table 8.4

Table 8.4
Case Study Programme

	Alpha	Beta	Omega
First Round			
Chairman	Yes	Yes	Yes
Non Executive	Yes	Yes	Yes
CEO	Yes	Yes	Yes
Executive	Yes	Yes	Yes
Auth Meeting	Yes	Yes	Yes
Non Public Meeting	Authority Seminar	Private part of Auth Mtg	Full 'Pre Meeting'
Second Round			
Chairman	Yes	Yes	Yes
CEO	Yes	Yes	Yes
Auth Meeting	Yes	Yes	Yes
Non Public Meeting	Private part of Auth Mtg	Private part of Auth Mtg	
Notes	Attended public mtg re: local services		Interviewed Secretary to the Board
	Approach Regional Health Authority		

A proforma was developed (see **Appendix 4**) to facilitate the recording of events i.e. the collective 'drama', verbal and non-verbal behaviour. Such meetings varied in length but typically were of 3-4 hours duration.

8.4.3 Documentary Sources In the course of the interviews and in attending board meetings a range of documents were made available either as a product of a particular interaction or as a part of a board's pattern of activity - at no time was any requested document denied. These documentary sources were, for example, Authority agendas and papers, private papers, policy documents, annual and/or public health reports. In some instances job descriptions were also provided.

All such records are, however, vulnerable to observer inference. Lofland & Lofland (1984, p51) suggest the following questions before the data is written up:

* is the report first hand ?
* what was the spatial location of the observer ?
* did the research participant have any reason to give false or biased information ?
* is the report internally consistent ?
* can the report be validated by using other independent reports ?

The nature of these reforms i.e. the introduction of private sector boards is likely to be a process of slow adjustment. It was important, therefore, to introduce a longitudinal element into the design which required two visits to each case study site, some 6 months apart. Aside from the desirability of this, in a processual sense, it also reinforced notions of methodological and data triangulation (Pettigrew, 1973; 1979).

The **analysis of the data** to come from the case studies Nachmias & Nachmias (1992, p282) suggest should include hypothesis building, examining frequencies and looking for regularities and patterns. Yin (1991, p109) proposes pattern matching, explanation building and time series analysis. Both, however, address the following:

* what type of behaviour is it ?
* what is its structure ?
* how frequent is it ?
* what are its causes ?
* what are its processes ?
* what are its consequences ?
* what are peoples strategies ?

(Loftland & Loftland, 1984 p94)

Easterby-Smith *et.al.* (1991, p105) suggest that there are two important strands,

> "In one, often known as content analysis the researcher 'goes by numbers' and 'frequency'; in the second, which we label 'grounded theory', the researcher goes by feel and intuition, aiming to produce common or contradictory themes and patterns from the data which can be used as a basis of interpretation."

Grounded theory is particularly important in the context of this investigation since it is the perspective which will be used to draw out the insights from the case studies. Easterby-Smith *et.al.* (1991, p108-112) identify the analytical processes as familiarisation, reflection,

conceptualisation, cataloguing concepts, recoding, linking and re-evaluation. As Jones (1987, p25) pointed out grounded theory works because "rather than forcing data within logico-deductively derived assumptions and categories, research should be used to generate grounded theory, which 'fits' and 'works' because it is derived from the concepts and categories used by social actors themselves to interpret and organise their worlds."

8.5 Reflections on the Case Study Experience

The case studies were a primary source of data. In many studies the case study is relegated to an almost secondary role, as a means of exploring the issues and testing ideas prior to much more 'substantive' investigation. The case studies provided qualitative and detailed insight and addressed the issue Bryman (1989, p231) has described as the "ecological fallacy" - that findings at an aggregate level may not be the same as those at an individual level (Robinson, 1950). The case studies thus provided both data in their own right and acted as a means of verifying the survey findings.

In practice, the dimensions of "getting in, getting on, getting out and getting back" (Buchan *et.al.*, 1988) are central to successful case study research. Getting in was in all cases by direct approach to and negotiation with the Authority's Chairmen. They were properly wary and agreement

followed a written case, verbal 'presentation' careful questioning and much reassurance. Failure to convince a Chairman would have meant the demise of that particular case site.

Progress depended upon honouring the psychological contract and exercising sound political and inter-personal skills. All sites were helpful and supportive, latterly being prepared to engage in high level disclosure almost without limit. In part this depended upon the role adopted by the researcher, and in striking the right balance between expert and novice. A high level of understanding and sensitivity was necessary almost as a pre-condition of entry, some degree of 'ignorance' a justification for the apparently naive question. This balance, and the relationships, were sustained across all three sites ensuring re-entry on the second round visits. Feedback was, however, agreed with two of the three sites and in all cases the Chairmen agreed to read and comment upon draft material. This had the benefits of honouring obligations regarding anonymity and feedback, and, addressing the issue of construct validity.

Bryman (1989) has identified a number of issues in organisational research, three of which bear directly upon the case study experience. Firstly, there is the issue of organizational effectiveness (ibid, p233). This research is *not* concerned with the effectiveness of District Health

Authorities *per se* but rather with the practice of corporate governance. Although the latter is likely to be a critical influence upon the former they are not synonymous. This distinction was important when negotiating entry to the case study sites. Secondly, organisational research is beset by problems of time (ibid, p239) [see, for example, Peters & Waterman (1982), who described "excellent" companies but which subsequently went into decline]. For this reason the case studies contained a longitudinal dimension in an effort to establish temporal validity. Finally, there is a problem associated with applied research (ibid, p244) and the tension between objectivity and rigour. In applied research it is all too easy to get too close to the subjects, to become a part rather than an observer of the drama. This can lead to 'contamination' of the data or to a softer and more organic outcome - see comments upon Ham in Chapter 6.

8.6 Conclusions

This chapter has sought to explore the practicalities of the postal survey (pilot study and main survey) together with a consideration of survey administration and response rate(s). In addition, the chapter has considered at some length the facets of the case method, including the 'politics' of gaining entry, managing relationships and disengagement. The success with which these precepts were applied can be judged from the findings from the postal

survey and case studies respectively. Before turning to these, however, it is important to consider in some detail the findings of the pilot study, to which we now turn.

- Chapter 9 -

The Pilot Study

9.1 Introduction

Chapter 8 considered in some detail the issues and practicalities associated with the methods to be used in this research, including the value of a pilot study to evaluate the data collection instruments, survey administration procedures and data analysis. This chapter reports the detailed findings from the pilot study and discusses these from both a topic and methods view point.

9.2 The Findings

9.2.1 The Respondents All Executives and Non-Executive Directors within a single Regional Health Authority were invited to complete a postal questionnaire - see **Appendix 1** - during the course of July, 1993. Given the nature of the exercise the sample was not intended to be representative.

Of the 63 directors then in post, 49 returned a completed questionnaire which represented a response rate of 77.8%. This was achieved from an initial mailing and from a single written reminder. Of those who replied 53% were Chairs/Non-Executives and 47% were CEOs/Executives - see **Fig 9.1.**

Two thirds had occupied their present role for 2 years or more, one third for less than two years - see **Fig 9.2.** This tends to support the contention of "continuity" rather than "change" in the membership of District Health Authorities (Ashburner *et.al.*, 1991).

73.5% of respondents were male and 26.5% female. The majority of women respondents were Chairs/Non Executives; women Executives remain under represented - see Table 9.1. The proportion of women recently appointed is, however, on a par with their male colleagues - see Table 9.2.

Table 9.1
Crosstabulation of Gender by Member Type

	Base	Male	Female
	49	36 73.5%	13 26.5%
Chairman	3 6.1%	2 4.1%	1 2.0%
Non Executive Member	23 46.9%	14 28.6%	9 18.4%
Chief Executive	4 8.2%	4 8.2%	0
Executive Member	19 38.8%	16 32.7%	3 6.1%

Table 9.2
Crosstabulation of Gender by Tenure

	Base	Male	Female
	49	36 73.5%	13 26.5%
Less than 2 years	15 30.6%	7 14.3%	8 16.3%
2-5 years	22 44.9%	19 38.8%	3 6.1%
More than 5 years	12 24.5%	10 20.4%	2 4.1%

Fig 9.1
Pilot Study Respondents by Role

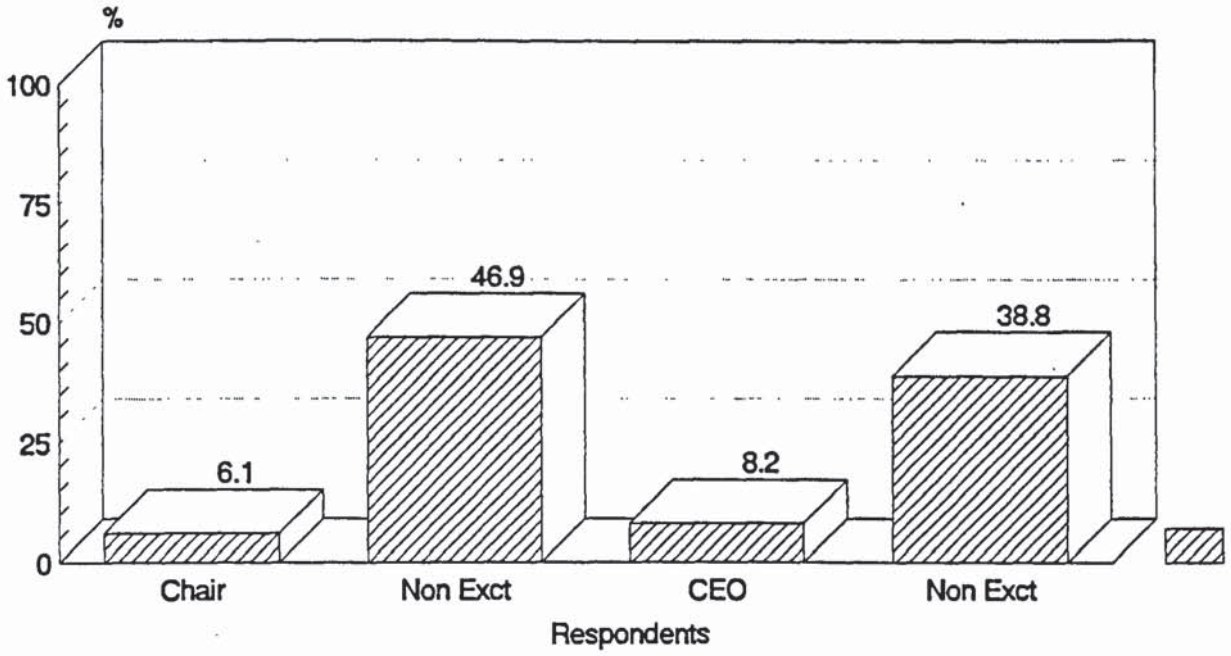
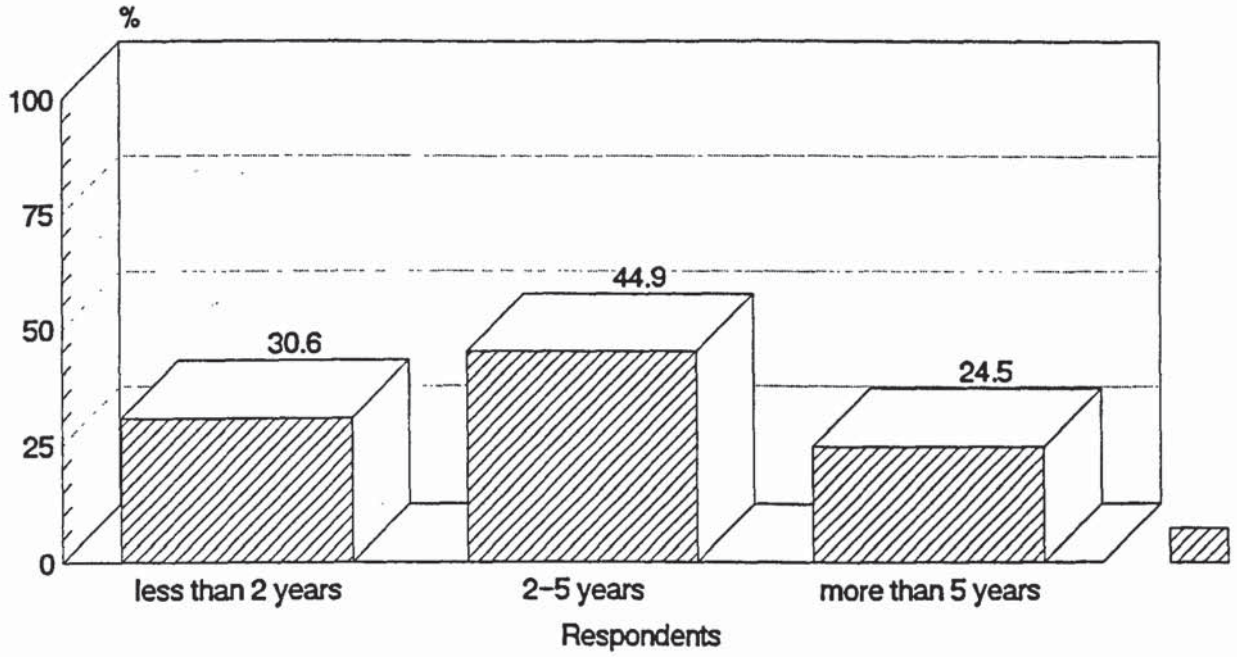


Fig 9.2
Tenure of Pilot Study Respondents



All age ranges between 30 and 79 years were represented, with the majority falling in late middle life - see **Fig 9.3.**

Of those respondents who were Chairs/Non-Executives, (effectively) the smallest proportion had been drawn from the private sector and the largest from the public sector - see **Fig 9.4.** This again implies continuity rather than change and may also suggest a tendency to 'conservatism' in such Authorities.

Those who were Executive directors, CEOs and Directors of Finance were the most likely to respond and together they represented 43.4% of all Executive respondents. In terms of the Executive's antecedent discipline, a small proportion were from a clinical background, the highest proportion from an Admin. & Clerical background. The latter group have clearly been more successful in terms of an occupational strategy (Harrison & Nutley, 1993) and have colonised the more 'senior' Executive posts in the ratio of 2:1 - see Table 9.3.

9.2.2 Strategic Direction In reply to questions asking respondents if their Authority had discussed its purpose and established a mission statement, strongly affirmative responses were received to both i.e. 95.9% and 98% respectively. However, when asked if the mission stated to

Fig 9.3
Age Structure of Respondents

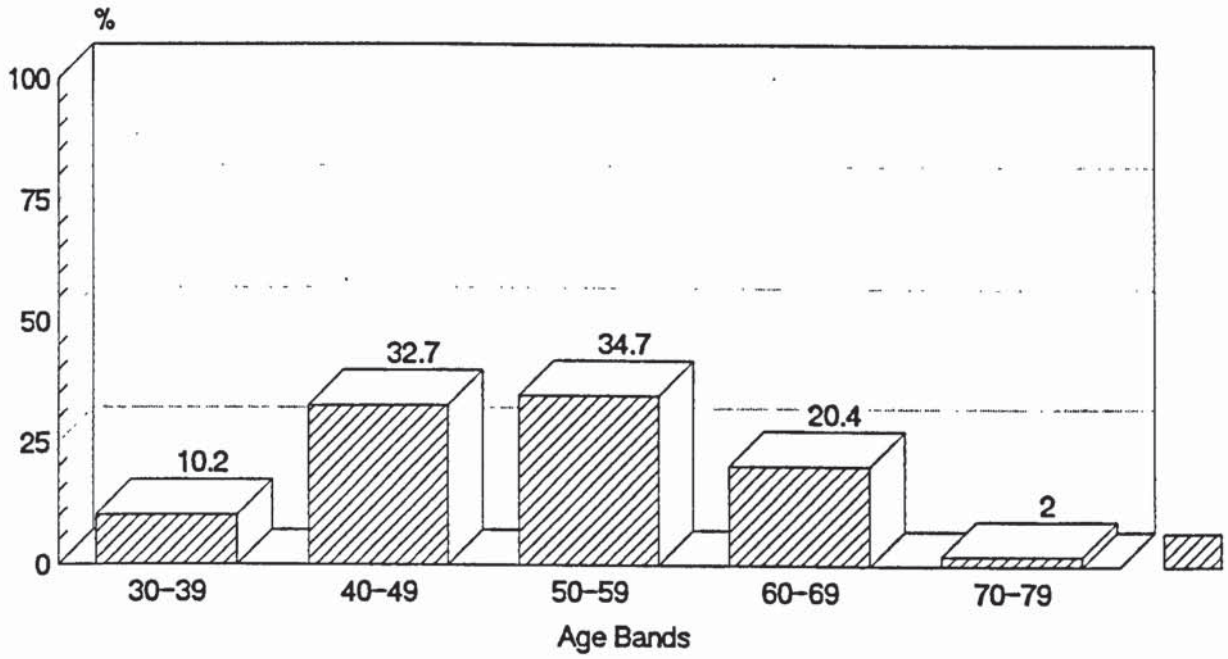
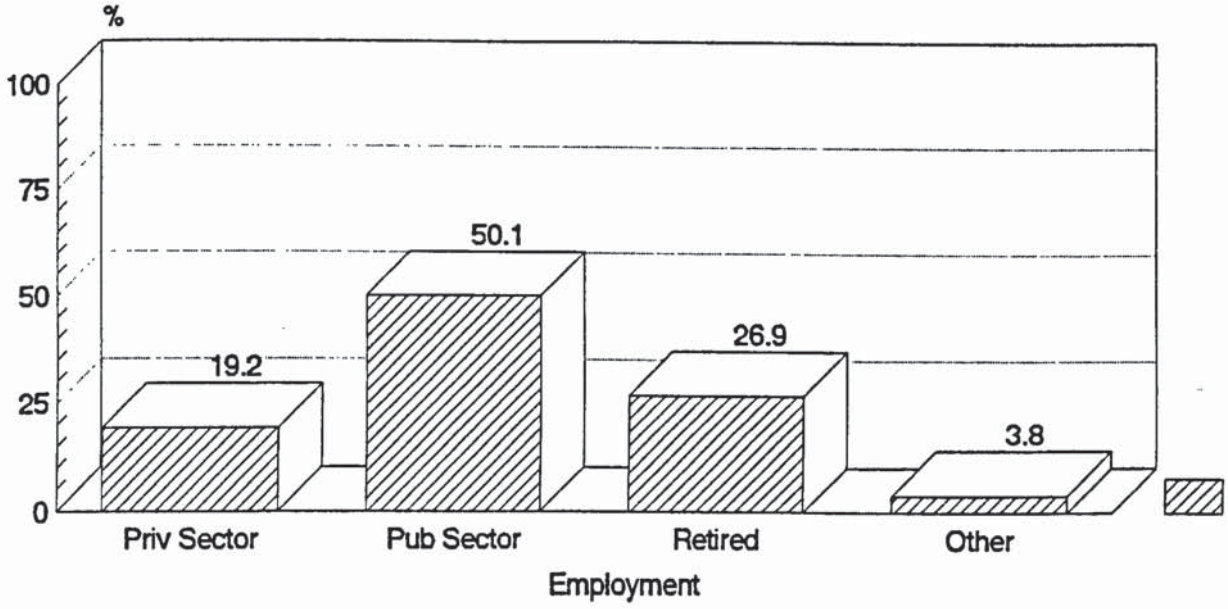


Fig 9.4
Employment Background of Non Executive Pilot Study Respondents



whom and for what the Authority was to be held accountable the response, while still positive, fell to 77.6%. Equally, when asked if the mission statement outlined the values the Authority would use as a basis of its judgements, the response was again 77.6%. See **Fig 9.5.**

These findings suggest that while purpose and mission have been discussed and documented this has not gone far enough. The rhetoric does not entirely match reality. About 1:5 Directors are unclear about their wider obligations to

Table 9.3
Crosstabulation of Discipline by Executive Role

Base = 23	Staff Group[1]	M&D	N&M	A&C	P&T	Other
		5 21.7%	2 8.7%	14 60.9%	1 4.3%	1 4.3%
General Manager	5 21.7%	0	0	4 17.4%	1 4.3%	0
Director of Finance	5 21.7%	0	0	5 21.7%	0	0
Director of Public Health	4 17.4%	4 17.4%	0	0	0	0
Director of Purchasing	3 13.0%	0	0	3 13.0%	0	0
Other	6 26.1%	1 4.3%	2 8.7%	2 8,7%	0	1 4.3%

to stake holders and slightly less deny or are ignorant of any moral or ethical under-pinning for the organisations decision making.

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[1] M&D = Mdical and Dental; N&M = Nursing and Midwifry; A&C= Administrative and Clerical; P&T= Professional and Technical.

In terms of the single most important strategic issue facing respondents, the greatest number identified questions of the organisation's boundaries/merger (55.1%) followed by a combined group of those taken up with contracting and/or commissioning (38.8%). No other single issue emerged to any significant degree, including finance, marketing etc.. This would suggest that these issues are either under control, not a priority, or are viewed as (relatively) insignificant - see **Fig 9.6**. The most likely explanation, however, is that the majority of Authorities *are* preoccupied with configuration issues despite the cultural rather than structural bias to health service reform.

When asked if priorities had been set for member involvement 61.2% stated this was the case, 34.7% that it was not. This would suggest that for 1:3 respondents there is no explicit or systematic involvement in the key strategic areas they had identified.

9.2.3 Executive Management When asked if the atmosphere in the boardroom encouraged frank discussion and permitted both Non-Executives and Executives to challenge assumptions, 98% of respondents agreed that this was so. A similar level of agreement was expressed when respondents were asked if Non-Executives and Executives could disagree with the Chair and therefore influence his/her decision.

Fig 9.5
The Relationship of Purpose and Mission to Accountability and Values

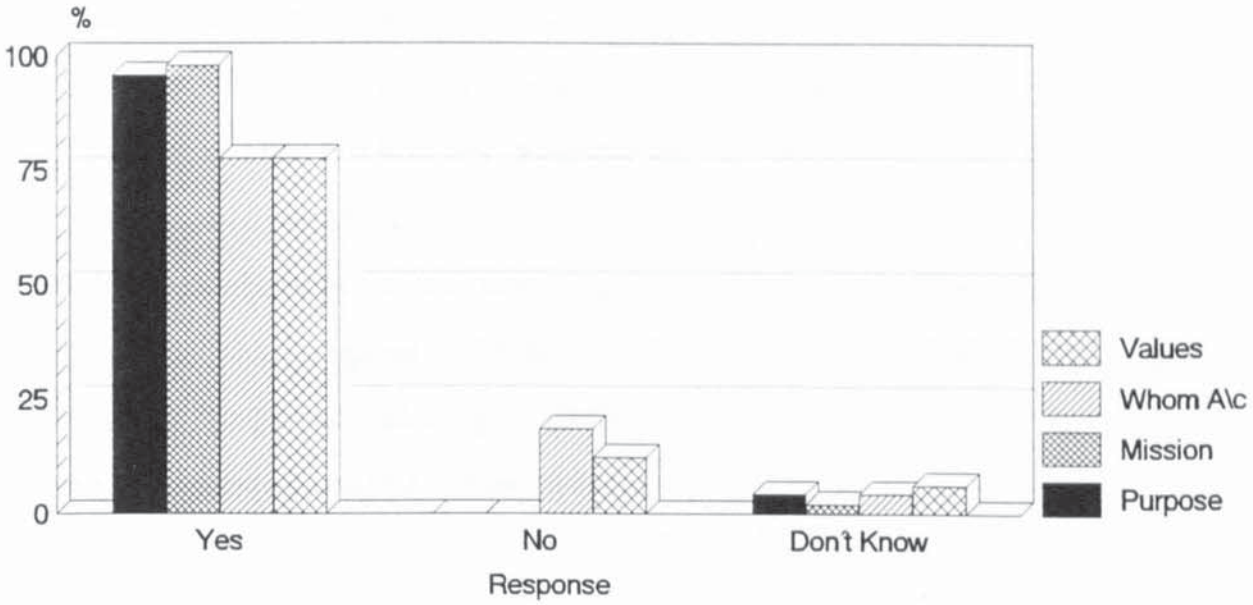
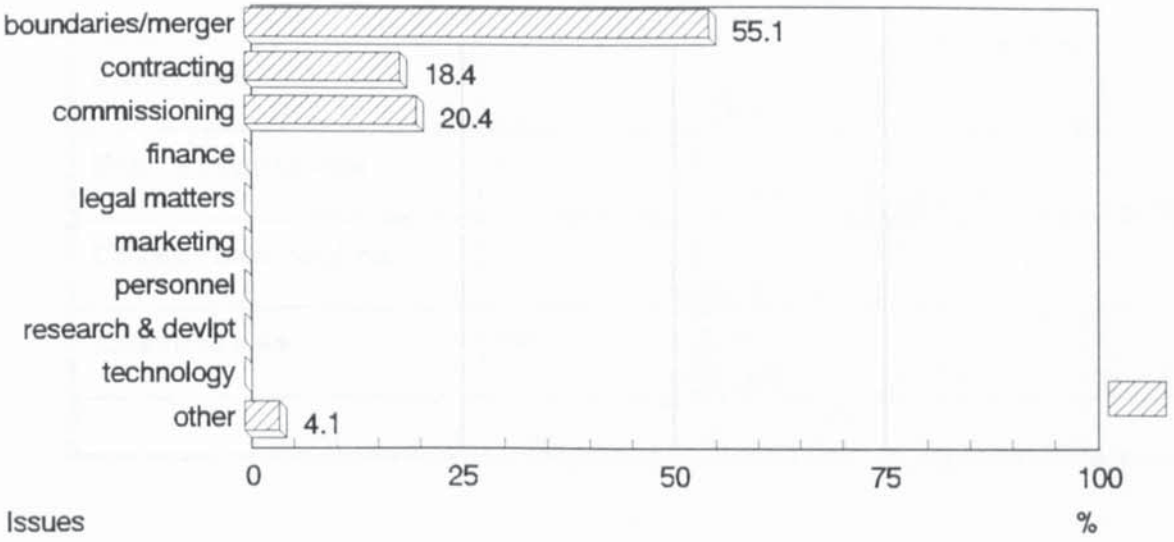


Fig 9.6
The Most Important Strategic Issue Facing District Health Authorities



If the atmosphere and the nature of the debate is as open as such responses would seem to indicate, what of the substance of executive management ? When asked if Non-Executives and Executives have the opportunity to place items on the Authority agenda 81.6% replied that they did. Nearly 1:5 denied or did not know if this was the case. Of those respondents in the latter categories, Non-Executives formed the highest proportion and women directors were nearly half as likely again to hold such views as their male counter-parts. See Tables 9.4 and 9.5.

Table 9.4
Crosstabulation of Access to Agenda by Director Type

	Base	Yes	No	Don't Know
	49	40 81.6%	5 10.2%	4 8.2%
Chairman	3	3 100%	0	0
Non Executives	23	15 68.2	4 10.2%	3 13.6%
Chief Executive	4	4 100%	0	0
Executives	20	18 90.0%	1 5.0%	1 5.0%

Table 9.5 Crosstabulation of Access to Agenda by Gender				
	Base	Yes	No	Don't Know
	49	40 81.6%	5 10.2%	4 8.2%
Male	36	30 83.3%	4 11.1%	2 5.6%
Female	13	10 76.9%	1 7.7	2 15.4%

When the substance for debate was clear, however, the overwhelming manner of decision making was by consensus (85.7%) and, to a much lesser degree, voting (14.3%). See **Fig 9.7**. The majority of directors saw their contribution as being generalist (42.9%) or corporate (36.7%). Only 20.4% saw themselves as specialists. Of the Executives in this latter group, Directors of Finance and of Public Health were more likely to hold this view - see Table 9.6. Whatever the perception of the nature of their contribution, when asked who made most decisions 91.8% of respondents identified Executive directors.

Table 9.6 CROSSTABULATION OF CONTRIBUTION BY EXECUTIVE ROLE				
	Base	Special-ist	General-ist	Corpor-ate
	23	6 26.1%	3 13.0%	14 60.9%
General Manager	5 21.7%	0	2 8.7%	3 13.0%
Dir Finance	5 21.7%	2 8.7%	0	3 13.0%
Dir Public Health	4 17.4%	2 8.7%	0	2 8.7%
Dir Purchasing	3 13.0%	0	1 4.3%	2 8.7%
Other	6 26.1%	2 8.7%	0	4 17.4%

9.2.4 Supervision Those surveyed were asked to indicate the existence of audit, remuneration or management review committees. No single respondent did so.

When asked if timely and appropriate information was provided to the Board 69.4% of respondents agreed that this was so. 79.6% agreed that the information provided supported monitoring and strategic control.

Respondents were asked to indicate if the Authority reviewed its own working style on a regular basis; 63.3% agreed. When asked if the Chair reviewed the performance of Non-Executive directors on a regular basis 36.7% agreed.

Although, without exception, Chairs indicated that this was the case, a significant proportion of [their] Non-Executives did not support this view - see Table 9.7. However, when asked if the Chair and Non-Executives regularly scheduled reviews of the Executives 16.3% agreed that these took place - see **Fig 9.8.**

Table 9.7
Crosstabulation of Chair's Review of NEDs by Non-Executive Role

	Base	No Reply	Yes	No	Don't Know
	26	1 3.8%	7 26.9%	4 15.4%	14 53.8%
Chairman	3 11.5%	0	3 11.5%	0	0
Non Executive Member	23 88.5%	1 3.8%	4 15.4%	4 15.4%	14 53.8%

The nature of the relationship between non executives and executives was characterised as close (30.6%), cordial (67.3%), tense (2%). No one regarded it as distant (0%).

9.2.5 Accountability When asked if there was a shared sense of corporate identity, 95.9% of respondents agreed that this was the case. 89.8% agreed that there was clarity about the boundary between the Chair and the CEO. We are able to conjecture, therefore, that there is a high level of agreement amongst respondents as to the nature of the shared organisational reality, and, that the focus of leadership - and therefore accountability - is unambiguous.

Fig 9.7
Decision-Making Styles of District Health Authorities

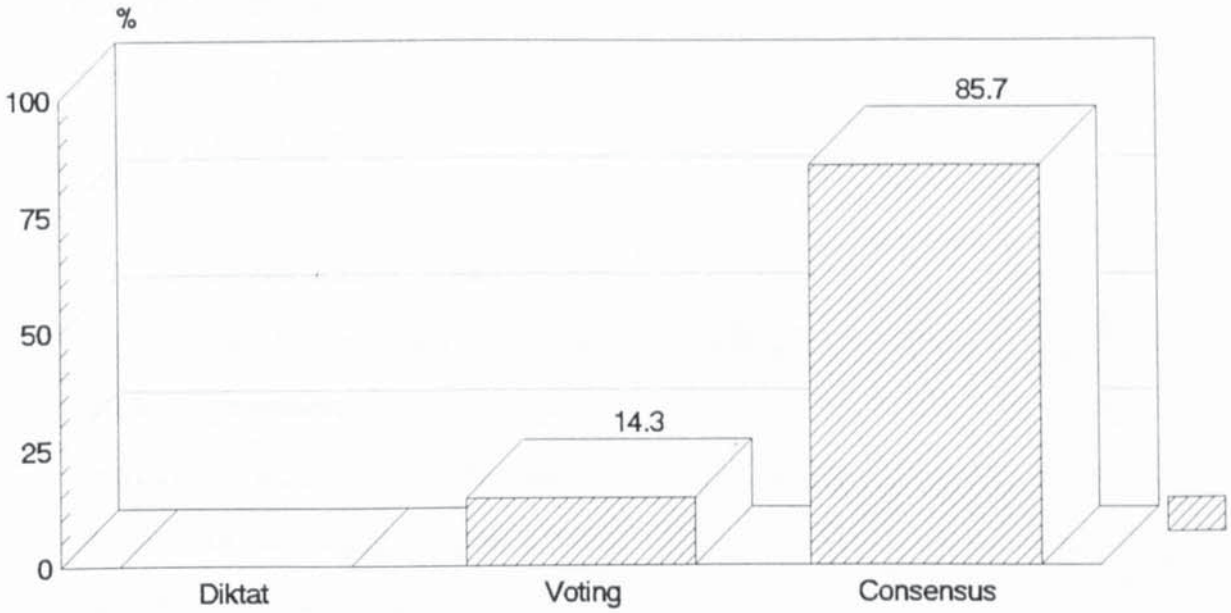
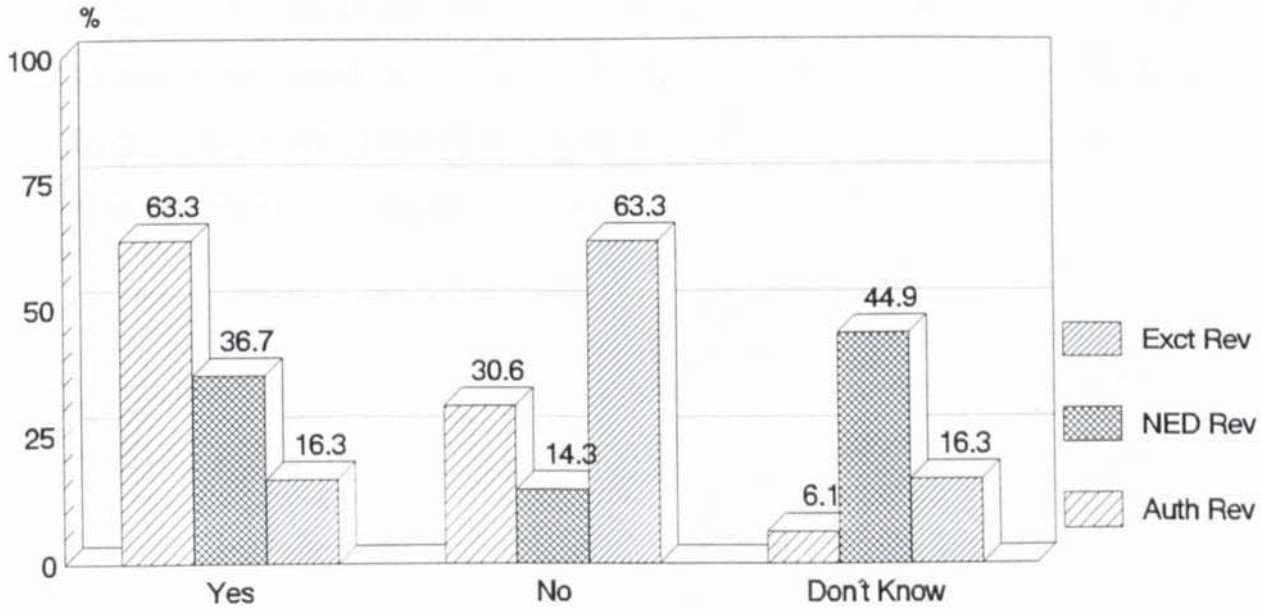


Fig 9.8
Review Practice within District Health Authorities



When asked how frequently their Authority met in public, the majority indicated 4-6 times per annum - see **Fig 9.9** Given that many pre reform DHAs met on a monthly public basis, this represents a reduction in transparency of nearly half.

Respondents were asked if they thought it was important to act in an ethical manner, to which there was 100% agreement. When asked if their Authority had an explicit ethical code only 30.6% agreed that this was so. This was brought into sharp relief when respondents were asked if any Non-Executive had declared a potential conflict of interest which 38.8% of respondents indicated had taken place - see **Fig 9.10**

All agreed the importance of acting ethically, yet only 1:3 reported the existence of an explicit ethical framework. Against this backdrop, there was an unexpectedly high level of reported conflict of interest, a perception Chairs did not appear to share - see Table 9.8

Fig 9.9
Frequency of DHA Public Meetings

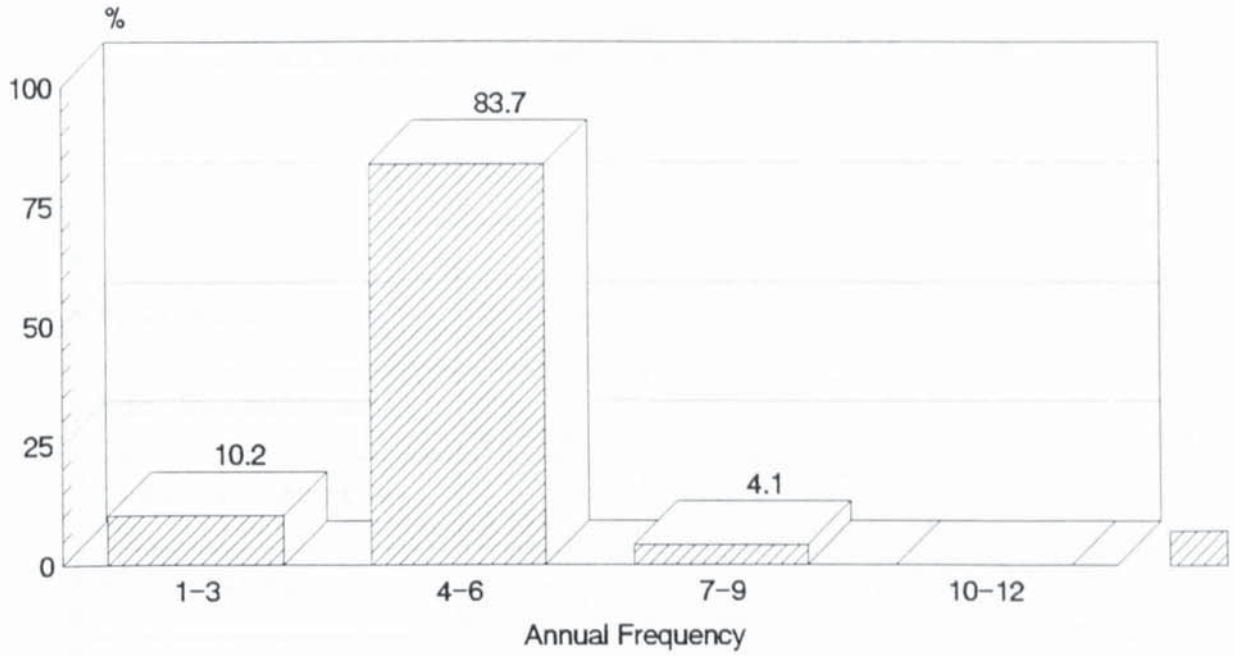


Fig 9.10
The Relationship of Ethical Aspiration to Practice and Experience in DHAs

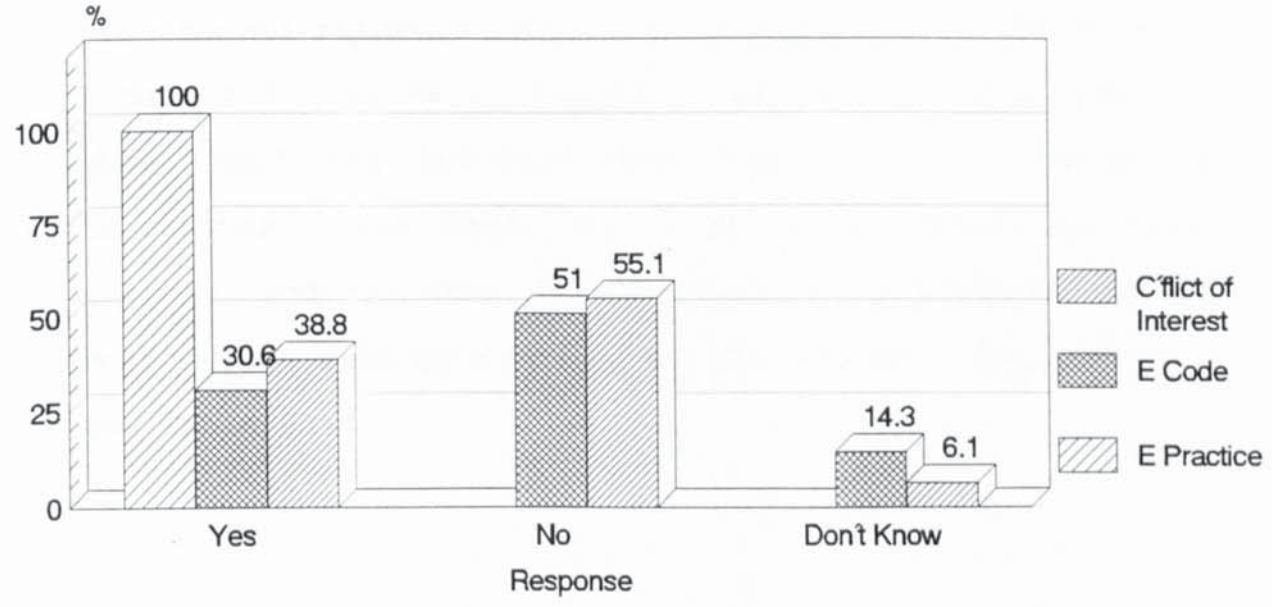


Table 9.8 Crosstabulation of Conflict of Interest by Director Type				
	Base	**Yes**	**No**	**DK**
	49	19 38.8%	27 55.1%	3 6.1%
Chairman	3 6.1%	0	3 6.1%	0
Non-Executives	23 46.9%	7 14.3%	13 26.5%	3 6.1%
Chief Executive	4 8.2%	3 6.1%	1 2.0%	0
Executives	19 38.8%	9 18.4%	10 20.4%	0

9.2.6 Key Influences upon Performance

Induction. A little more than two thirds (67.3%) of respondents reported receiving an induction or orientation into their role as a director. This was not the case for about half the Non-Executives and about a quarter of Executives - see Table 9.9. The number reporting this, however, reduces when one compares the experience of the most recent with that of the longest standing appointees - see Table 9.10.

Table 9.9
Crosstabulation of Induction by Director Type

	Base	Yes	No	DK
	49	33 67.3%	14 28.6%	2 4.1%
Chairman	3 6.1%	3 6.1%	0	0
Non-Executives	23 46.9%	12 24.5%	11 22.4%	0
Chief Executive	4 8.2%	4 8.2%	0	0
Executives	19 38.8%	14 28.6%	3 6.1%	2 4.1%

Table 9.10
Crosstabulation of Induction by Tenure

	Base	Yes	No	DK
	49	33 67.3%	14 28.6%	2 4.1%
Less than 2 years	15 30.6%	12 24.5%	3 6.1%	0
2-5 years	22 44.9%	13 26.5%	7 14.3%	2 4.1%
More than 5 years	12 24.5%	8 16.3%	4 8.2%	0

Statutory Obligations and Legal Responsibilities. 55.1% of respondents indicated that they had been provided with this information, 36.7% had not and 8.2% did not know. In short, nearly half of all respondents were unclear about their obligations and responsibilities. This was fairly evenly

distributed amongst directors of all types, except for Chairs who appear to be clearest about such matters - see Table 9.11. Recently appointed directors appear somewhat more informed than those of longer standing - see Table 9.12

Table 9.11
Crosstabulation of Knowledge of Obligations by Director Type

	Base	Yes	No	DK
	49	27 55.1	18 36.7%	4 8.2%
Chairmen	3 6.1%	3 6.1%	0	0
Non-Executives	23 46.9%	13 26.5%	8 16.3	2 4.1%
Chief Executives	4 8.2%	2 4.1%	2 4.1%	0
Executives	19 38.8%	9 18.4%	8 16.3%	2 4.1%

Table 9.12
Crosstabulation of Knowledge of Obligations by Tenure

	Base	Yes	No	DK
	49	27 55.1%	18 36.7%	4 8.2%
Less than 2 years	15 30.6%	11 22.4%	2 4.1%	2 4.1%
2-5 Years	22 44.9%	10 20.4%	11 22.4%	1 2.0%
More than 5 years	12 24.5%	6 12.2%	5 10.2%	1 2.0%

Personal Influence. When asked who had the most significant influence upon their role locally, a varied picture emerged - see Table 9.13. Two things are clear. Firstly Chairs generally see themselves as being most influenced by their CEO and *vice versa*. A not unexpected finding which accords with Stewart's findings (Stewart, 1987a). Secondly, 4.8% of respondents (who were Chairs), 11.9% (who were Non-Executives) and 38.1% (of Executives) - 54.8% in all - claim that the CEO is the most significant influence upon them. This compares with a total of 23.8% for District Health Authority Chairs. The CEO is clearly a pivotal figure and, at more than twice as influential as Chairs upon their board colleagues, a significant focus for promoting and sustaining effective performance.

Table 9.13
Crosstabulation of Role Influence by Director Type

	Base	Chair	Non Exct	CEO	Excts
	42	10 23.8%	3 7.1%	23 54.8	6 14.3
Chairman	3 7.1%	0	0	2 4.8%	1 2.4%
Non Executives	18 42.9%	6 14.3%	3 7.1%	5 11.9%	4 9.5%
Chief Executive	4 9.5%	4 9.5%	0	0	0
Executives	17 40.5%	0	0	16 38.1	1 2.4

9.3 Methodological Issues

9.3.1 The Data Collection Instrument. The pilot study was an important opportunity to test the postal questionnaire (see Appendix 1) and to evolve it for use in the main postal survey (see Appendix 2). Phrasing and presentation generally were both improved; also the range of responses offered in selected questions. The main difference, however, was the addition of questions dealing with ethnicity, the company secretary role, the publication of an annual report, the implementation of board decisions and relations with stake holders.

9.3.2 Survey Administration. The procedures associated with the administration of a postal survey:

* drawing the sample
* producing the required numbers of questionnaires and covering letters
* organising envelopes, labels, postage and mailing out
* recording responses, and,
* sending out reminders

were all tested in the pilot study. The process was completed without incident and proved satisfactory in every way. Two points were, however, revised in the light of piloting. Firstly the lead time for the main postal survey was increased in recognition of the much larger numbers involved. Secondly, in the main postal survey each returned

questionnaire was logged against a return following the initial mailing, the first or second reminder. In this way it was possible to both measure progress with response and to assess the value of reminders, in real time and retrospectively.

9.3.3 Data Analysis and Reporting. Many pilot studies set out to test data collection and survey procedures but lose interest almost completely in the data that the pilot study yields. An important element of this pilot was, however, to test data entry, analysis and reporting. The survey analysis software - SNAP 2 - was used and data entry, manipulation and analysis all proved satisfactory.

The findings from the pilot were reported (Harrison, 1994) - see Appendix 5. This was undertaken to both develop skills in this sphere and to establish - in some measure - a source of longitudinal comparison. As noted in Chapter 4 an abridged account of the pilot study findings was submitted as evidence to the NHS Corporate Governance Task Force in the autumn of 1993.

9.4 Discussion

In common with much research, this (pilot) study raises as many questions as it answers. It is, of course, important to remember that the 'sample' is small and therefore not necessarily representative, and so, the

findings need to be interpreted with caution. That said, however, the findings do provide a timely insight - falling as they do in the post Cadbury/pre Corporate Governance Task Force period - into the perceptions and practice of board members in the constituent District Health Authorities of a single English RHA. Key themes to emerge from this initial study are as follows.

9.4.1 Strategic Direction. It is clear that directors perceive the importance of their contribution in this area but these data suggest that there is some discrepancy between the apparent and the real e.g. the existence of a mission statement but some uncertainty about stake holders. Equally, a clear pattern of priorities is evident but there was little systematic involvement of some board members.

9.4.2 Executive Management. A litmus question in this area concerned the ability of directors to place items on the boards agenda. 20% of respondents were uncertain or doubted their ability to do so. Given that many of those who held such a view were Non-Executives, and in particular female directors, this may imply a difference between the powerful and the powerless. The presence of outside directors or the inclusion of women on a board may not in itself guarantee either acceptance or an acceptable performance. Also important is the perception of about a quarter of Executives who saw themselves as specialists. Such a view may both narrow their own contribution and

reduce the nature and quality of the wider debate. Whilst matters of health policy and management - at this level - must in part be 'technical', this may also be used as a device to subdue Non-Executive involvement (or confine the Executive role within strict, and familiar, boundaries). Were Non-Executives to be so influenced, they may be reluctant to raise agenda questions? They may also be reluctant to shape or challenge the decisions which, by common consent, are made predominantly by Executives?

9.4.3 Supervision. The evidence here is unequivocal. No respondent reported the existence of an audit, remuneration or management review committee. Equally, the level of agreement that the Authority, the Non-Executive directors, and, the Executives are explicitly and systematically reviewed falls progressively and sharply. This is not to suggest that supervision is absent. Clearly this is not the case, but subtle mechanisms may be both less obvious and less robust. Effective corporate governance demands that such processes be made manifest. Also important, is the near unanimous view that relations between the parties are close or cordial; this may suggest a degree of Non-Executive capture.

9.4.4 Accountability. Here again the picture is one of inconsistency. As noted above, respondents had only a partially formed view of, and their responsibilities toward, stake holders. This may offer some explanation of

the substantial reduction in the extent to which District Health Authorities conduct their business in public. The level of ethical aspiration expressed was commendably high but, not unlike strategic direction, actual performance was somewhat different. With 1:3 reporting a conflict of interest by a Non-Executive director, evidence of a formal ethical code was slight.

Whilst the picture detailed above is far from unremitting gloom - particularly in terms of recent appointments - there is room for improvement. More even coverage in terms of induction and orientation would be beneficial. However, progress could be greatly facilitated by the publication of a clear statement of directors' statutory obligations and legal responsibilities which was systematically communicated to *all* directors. It will be important to recognise, in developing guidance upon corporate governance, that Executives play a significant part in a board's affairs. In particular the CEO was a role model and source of influence for more than half of those surveyed. Whilst it is not suggested that this represents a challenge to the *primus inter pares* role of the Chair, it does suggest a level of influence which conventional wisdom may tend to underestimate.

The challenges in terms of the remainder of the research programme are two fold. Firstly, to take the experience of the pilot study and use its influence to

improve the conduct of the main postal survey. Secondly and subsequently, to explore the relationship of reported practice and actual behaviour *in situ* and over time. By such joint means it will be possible to develop a contextual understanding of how the boards of District Health Authorities actually operate.

- Chapter 10 -

The Postal Survey: Board Membership and Strategic Direction

10.1 Introduction

All Executive and Non-Executive directors of the constituent District Health Authorities (DHAs) within three English Regional Health Authorities (RHAs) i.e. the West Midlands, Trent and Oxford RHAs were invited to participate in a postal survey between late November 1993 and early January 1994. Of the 332 Executive and Non-Executive directors then in post, 247 returned a completed questionnaire, representing a response rate of 74.4%. Chapter 8 described the methods adopted and analyzed fully response, non response and issues of survey administration. This chapter will begin to report the findings from the postal survey and - taking Tricker's model of corporate governance (Tricker, 1984) - begin by looking at the sphere of **strategic direction**. First, however, it is important to consider the characteristics of the respondents themselves. This will provide an insight into the nature and culture of DHA boards and be an important backdrop to a consideration of the remaining data.

10.2 The Personal Characteristics of Board Members

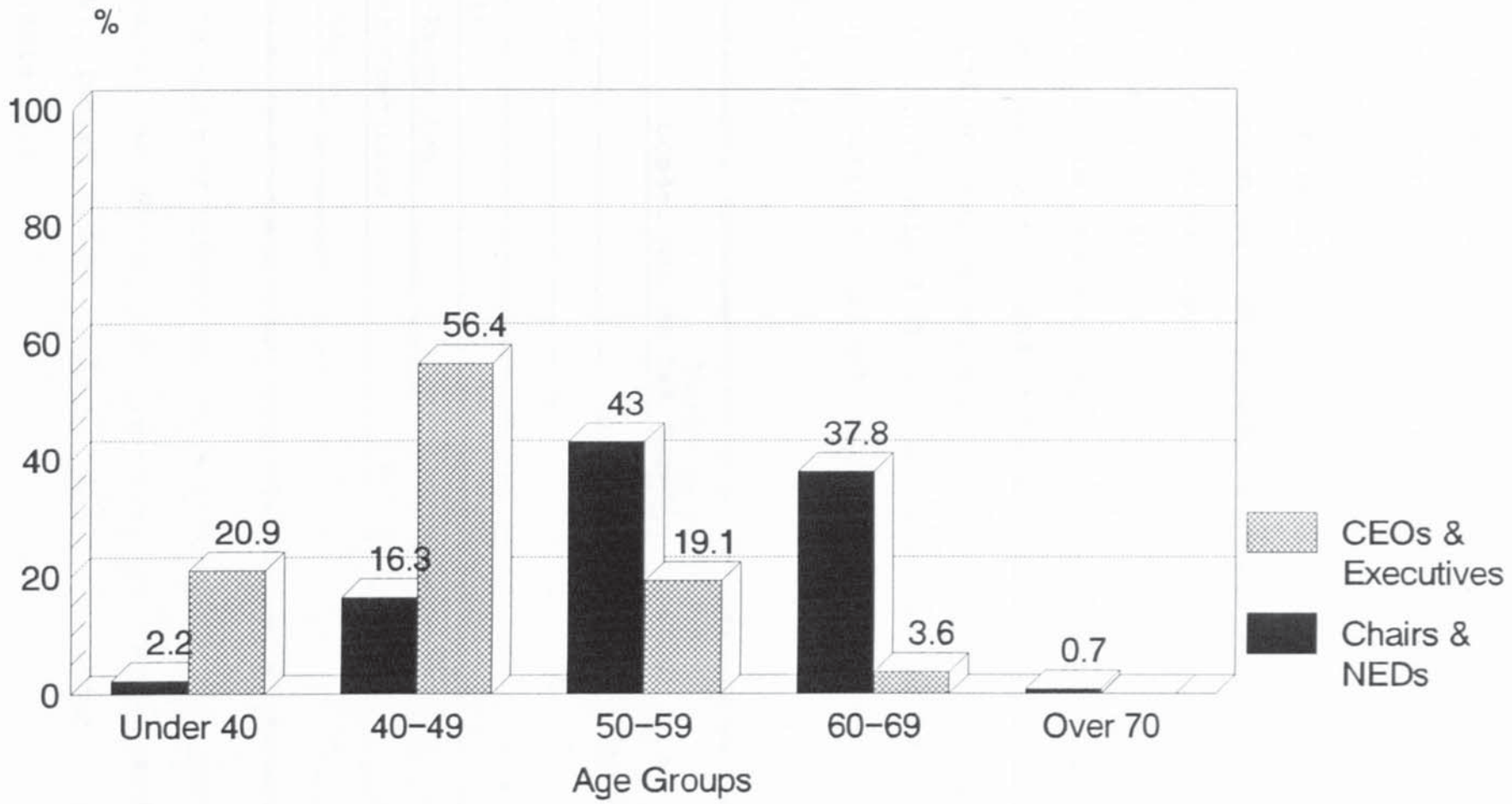
The complete array of adult age range(s) was represented in the respondents, with the majority concentrated in late middle life. When, however, the age pattern for Chairs/NEDs is compared with those of CEOs/Executives a higher proportion of the upper age ranges was found in the former than in the latter - see **Fig 10.1** Both findings concur with those of Cairncross *et.al.* (1991, p13).

72.9% of respondents were male and 27.1% female. This represents an increase of circa 4% in the number of women directors over that identified by Ashburner & Cairncross (1991, p22). Although women are represented to this degree their presence in individual Regions varied: the lowest in Oxford (20%) and the highest in Trent (30.1%) - see Table 10.1.

Table 10.1
Gender Mix of DHA Boards

	Male	**Female**
n = 236	172 (72.9%)	64 (27.1%)
Oxford RHA	24 (80.0%)	6 (20.0%)
Trent RHA	51 (69.9%)	22 (30.1%)
West Midlands RHA	97 (72.7%)	36 (27.1%)

Fig 10.1
Age Structure of Board Members



Women respondents were, however, twice as likely to be a Chair/Non-Executive directors than a CEO/Executive - an echo of the pilot study - and, for these women, only a 4% likelihood of being a CEO - see Table 10.2. Whilst the number of women in the boardroom falls short of their number in the wider population, they continue to increase steadily with 51.5% of all women directors having been appointed in the past two years. It is, however, important to judge these numbers and progress against the experience of the private sector where a survey carried out in 1991 indicated that only 3.9% of Non-Executive directors and 0.5% of Executives, on main boards, were women (Howe & McRae, 1991).

Table 10.2
Gender Mix of DHA Boards by Member Role

	Male	**Female**
n = 246	178 (72.4%)	68 (27.6%)
Chair	21 (87.5%)	3 (12.5%)
Non-Executive	72 (63.7%)	41 (36.3%)
Chief Executive	22 (95.7%)	1 (4.3%)
Executive	63 (72.4%)	24 (27.6%)

In terms of ethnicity, 96.7% of respondents described themselves as White, the remainder as Black Caribbean (0.4%), Indian (1.2%), Chinese (0.4%) and Other (1.2%) - see Table 10.3

Table 10.3 Ethnic Mix of DHA Boards		
	White	**Non White/Other**
n = 235	227 (96.6%)	8 (3.4%)
Oxford RHA	30 (100%)	0 (0%)
Trent RHA	72 (98.6%)	1 (1.4%)
West Midlands RHA	125 (94.7%)	7 (5.3%)

Unsurprisingly, perhaps, the proportion of ethnic minority members was "highest" in the West Midlands RHA which may simply reflect an area of 'geographical concentration' (Cairncross et. al., 1991). However, despite Ministerial statements:

> "Non-executive members and directors on the boards of NHS authorities and trusts have a vital role to play in todays health service. I am committed to increasing the proportion of people from different black and ethnic backgrounds who are appointed as chairmen and non-executive members, so that they can play a full part in the management of a service in which the whole community has an interest. Appointments must be made on merit alone but we must make the best use of all available talent and do more to attract people from different cultural backgrounds."
>
> (Cumberledge, 1994)

ethnic minorities are none-the-less conspicuous by their (near) absence around the boardroom table. As with gender, directors from an ethnic minority background are almost twice as likely to be Chairs/Non-Executive directors than CEOs/Executives. However, no Chair and (again) only one CEO

came from an ethnic minority background - see Table 10.4. Although half of all those respondents who were Non White/Other had been appointed in the previous two years, as a proportion of all those appointed in the same period, the numbers (although 5% and thus exceeding the Government's target) remain marginal.

Table 10.4
Ethnic Mix of DHA Boards by Member Role

	White	Non White/Other
n = 245	237 (96.7%)	8 (3.3%)
Chair	23 (100%)	0 (0%)
Non-Executive	108 (95.6%)	5 (4.4%)
Chief Executive	22 (95.7%)	1 (4.3%)
Executive	85 (97.7%)	2 (2.3%)

Of all directors, two thirds had occupied their present role for two years or more, one third for less than two years. This tends to support the contention of continuity rather than change in the membership of District Health Authorities (Cairncross et. al., 1991 p5) - see Table 10.5. A more detailed analysis of Chairs and Non-Executive directors reinforces further the notion of continuity, with some 39.1% of Chairs having occupied their role for more than 5 years - see Table 10.6

Table 10.5 "Tenure" of DHA Board Directors by RHA			
	Less than 2 years	**2-5 Years**	**More than 5 years**
n = 235	81 (34.5%)	121 (51.5%)	33 (14.0%)
Oxford RHA	16 (53.3%)	10 (33.3%)	4 (13.3%)
Trent RHA	23 (31.5%)	44 (60.3%)	6 (8.2%)
West Midlands RHA	42 (31.8%)	67 (50.8%)	23 (17.4%)

Table 10.6 "Tenure" of Chairs and NEDs			
	Less than 2 years	**2-5 years**	**More than 5 years**
n = 135	43 (31.9%)	70 (51.9%)	22 (16.3%)
Chairs	7 (30.4%)	7 (30.7%)	9 (39.1%)
NEDs	36 (31.9%)	64 (56.6%)	13 (11.5%)

69.6% of Chairs and 45.9% of Non-Executive directors described their employment background as being the "private sector" - see Table 10.7. This position - in marked contrast to that of the pilot study - is consistent with the notion of introducing this form of expertise and experience into the management of the public service (CM 555, 1989 para 8.5). In terms of the executive's antecedent discipline, the highest proportion came from an Administration & Clerical background (48.2%) which, again,

demonstrates the extent to which this group can be said to have pursued a successful occupational strategy (Harrison & Nutley, 1993).

Table 10.7
Employment Background of Chairs/NEDs

	Private Sector	Public Sector	Retired	Other
n = 133	67 (50.4%)	35 (26.3%)	17 (12.8%)	14 (10.5%)
Chairs	16 (69.6%)	4 (17.4%)	3 (13.0%)	0
NEDs	51 (45.9%)	32 (28.8%)	14 (12.6%)	14 (12.6%)

In contrast to the pilot study, a much higher proportion of Executive respondents came from a clinical background *per se* (circa 40%), but the number from a Nursing background remained relatively low (10.%) and concurs with the "apparent under-representation of human resource and (obviously) nursing experts" (Cairncross *et.al.*, 1991). The reasons for the low number of Executives with a nursing background are complex and may touch upon issues of gender and/or the fall from grace of less powerful professional groups. The significance, however, resides in a marked decline in experience of this type around the boardroom table in Purchasing Authorities against the statutory presence of nurses in the boardrooms of provider Trusts (Section 5, NHS & Community Care Act 1990).

10.3 The Personal Characteristics of Board Members: Discussion

The personal characteristics of board members have long been a source of fascination. In part this is because they offer some insight into a largely ill understood world and because of the relationship between the characteristics of directors and the performance of the boards upon which they serve.

The findings from this study are unremarkable in terms of age structure. This is not so in terms of the issue(s) of gender and race. Historically, the percentage of women on the boards of NHS bodies has been low, a trend which itself is now clearly in decline. Although some studies appear to report very high levels of female membership - e.g. Stern, Martin and Cray (1995) report 40% of Non-Executive directors in South Thames RHA being women - these need to be treated with caution. The steady rise between the "under-representation" described by Ashburner & Cairncross (1991) and the findings of this study (27%) is a more accurate picture of the present position.

The mere presence (or representation ?) of women on the boards of NHS bodies is, however, not enough. Some commentators have advanced an overtly gendercentric view by suggesting a "masculine" and "feminine" formulation of corporate governance, of which the latter "has consequences for women trying to work within its prescriptions" (Williamson, 1994b p26). Although in terms of the feminist

agenda this rehearses the male and female polemic; simply reinforcing the politics of disadvantage does little to increase understanding or effect progress. The work of Burke (1995) begins to cast some light on the impact women directors have upon board performance. Specific impacts include:

* raising issues of concern to women
* supporting "women friendly" policies
* helping the career advancement of managerial women
* serving as a role model
* providing other viewpoints, and,
* questioning the treatment of women

although 34% reported that they served on boards on which they were unable to make a "substantial contribution" (ibid, p141).

Turning now to ethnicity, the issue here is rather more fundamental. For black and ethnic minorities the questions are not about the nature and impact of their contribution but, rather, the fact that they are all but absent from the boardroom landscape. The findings from this study largely confirm that

> "although 5.5% of the British population now come from black and ethnic minority communities, out of 1531 non executive directors of RHAs, Trusts and Special Health Authorities only 45 are from black and ethnic communities; all RHA and Special Health Authority Chairs are white and out of 534 Trust, Health Authority and FHSA Chairs all but four are white."
>
> (Millar, 1993)

Despite Government targets, commitment and widespread debate throughout the service, progress is slow in absolute terms and in comparison with, for example, the issue of gender. More needs to done to ensure that the boards of public bodies more closely reflect the communities in which they find themselves. This is not to suggest that there is systematic discrimination but rather, recruitment via networks, inadequate information and a poor NHS profile within black and ethnic minority communities can and does exclude some individuals (NAHAT, 1993).

Finally, the importance of a director's background may be important both to the nature of their selection, their contribution and to their effectiveness. This might explain in part (until recently) the low numbers of women and, still, the low numbers of black directors on the boards of NHS bodies. Although the number of director changes would suggest rather more continuity than change, those who have joined the boards of NHS bodies in the previous two years were most likely to come, in order of likelihood, from the public or private sector or to be retired. There are no "unemployed" directors.

10.4 The Element of Strategic Direction in Corporate Governance

10.4.1 Tricker's Formulation A dominant influence in the literature is Tricker's model of corporate governance (1984) (also Hilmer & Tricker, 1990). In its original form it consisted of four fields - Strategic Direction,

Executive Management, Supervision and Accountability - this chapter is principally concerned with Strategic Direction.

> "The *direction* of a company involves the formulation of strategy and the acquisition and allocation of resources, setting priorities which guide and constrain management action and, broadly, establishing the direction the company is to take. It emphasises the mission of the business - the shared vision of possible futures and desirable directions for the enterprise."
>
> (Tricker, 1984 p174)

10.4.2 Strategic Direction In reply to questions asking respondents if the Authority had discussed its purpose and defined its role, strongly affirmative responses were received to both i.e. 87.9% and 77.2% respectively. 84.6% confirmed that their Authority had formulated a mission statement and, of these, 79.1% outlined the values used by the Authority as the basis of its judgements but only 61.6% reported that these stated to whom and for what the Authority would be held accountable. These figures - see **Fig 10.2** - again suggest that while purpose and mission have been discussed and documented they have yet to be articulated in an unambiguous form capable of being widely shared and understood, both by the board and its stakeholders. The extent to which one can be confident about the sense of direction boards offer District Health Authorities is in direct proportion to the extent to which they are capable of identifying and rectifying any difficulties in their own spheres of their operation. Only 48.5% of respondents reported that the board on which they

served had reviewed its own working style on a regular basis, 45.6% reported that it had not and 5.98% did not know.

In terms of the single most important strategic issue facing respondents, the greatest number identified a composite group concerned with contracting/commissioning (36.4%) followed by a group concerned with boundaries/mergers (35.1%). Other than finance (20.9%), all other categories were in single figures - see **Fig 10.3** Contracting/commissioning[1] has remained broadly similar to that identified in the pilot study but, has moved into first place largely due to a reduced preoccupation with issues of structure. That said, however, matters of boundaries/merger remain near the top of board's agendas despite NHS reform being promulgated in terms of *cultural* change. Secondly, finance moved from obscurity in the pilot study to being identified as the third most important issue by 1:5 respondents. Legal, marketing and personnel matters, research & development, and, issues of technology all remain marginal by comparison.

When asked if priorities had been set for member involvement 51.4% stated this was the case, 44.9% that it was not and 3.7% did not know. This would suggest that for half of all respondents there is no explicit or systematic

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[1] A rare reference to the relationship of corporate governance to DHAs/Purchasing organisations can be found in Ovretveit (1995).

Fig 10.2
The Relationship of Purpose and Mission
to Values and Acountability

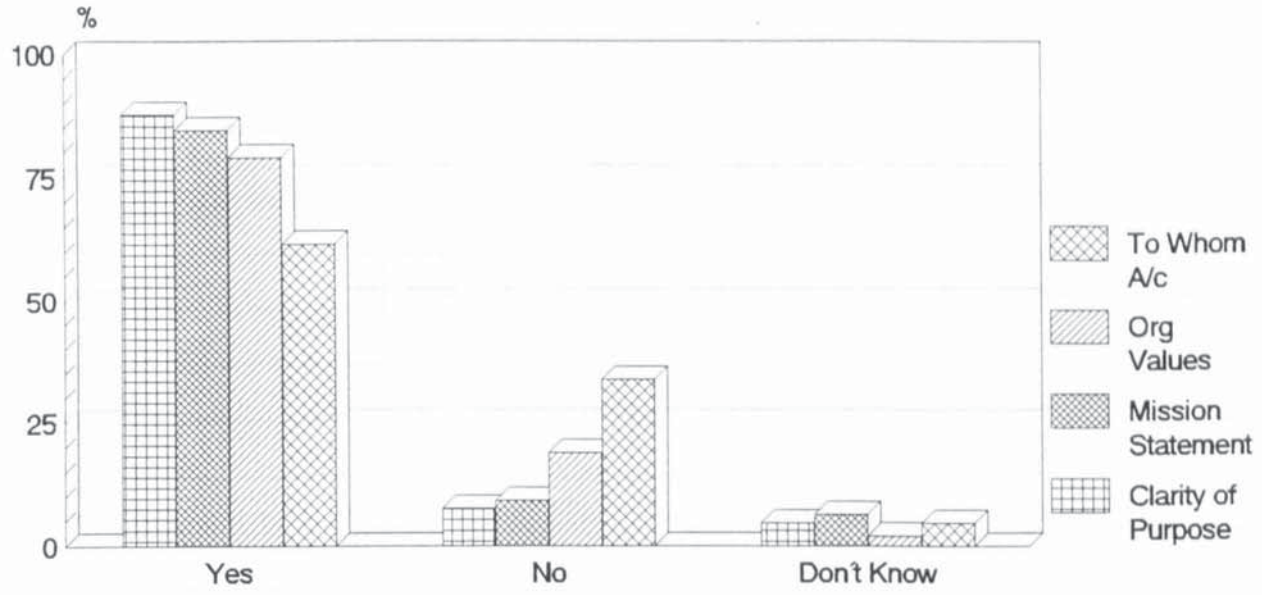
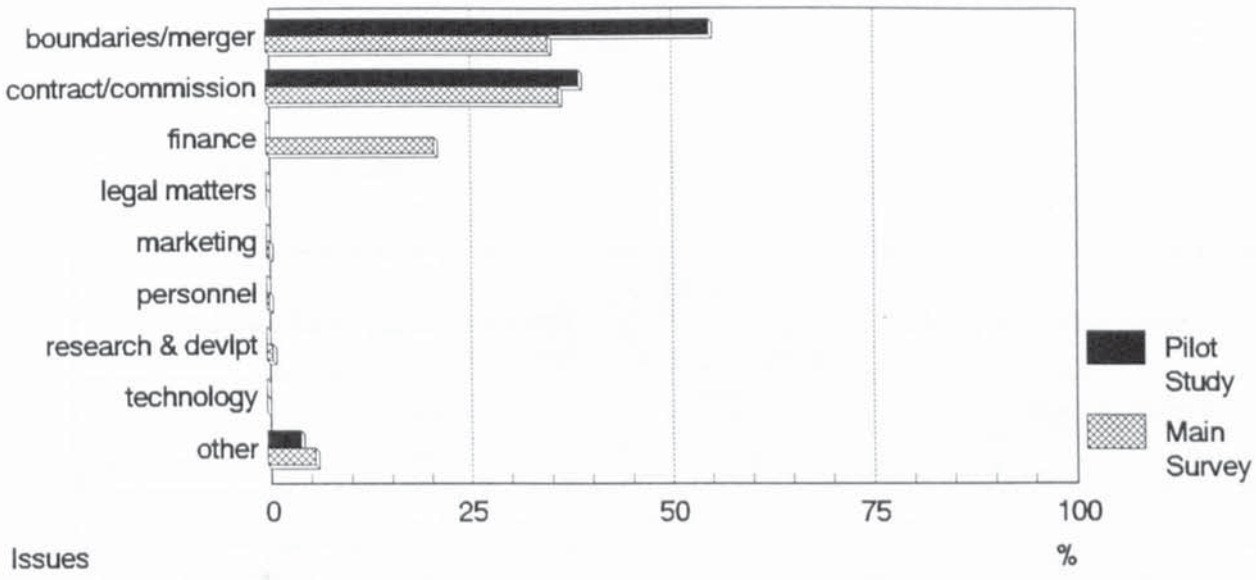


Fig 10.3
The Most Important Strategic Issue
Facing District Health Authorities



involvement in the key strategic issues they identified as being important to their board - see Table 10.8 This confirms the findings of the pilot study.

Table 10.8
Director Involvement in Identified Board Priorities by Board Role

	Yes	No	Don't Know
n = 243	125 (51.4%)	109 (44.9%)	9 (3.7%)
Chairs	12 (52.2%)	11 (47.8%)	0
NEDs	55 (49.5%)	51 (45.9%)	5 (4.5%)
CEOs	15 (62.5%)	8 (33.3%)	1 (4.2%)
Executives	43 (50.0%)	40 (46.5%)	3 (3.5%)

When involvement in priorities is examined by comparing the views of Chairs/CEOs with NEDs/Executives the former were more likely to believe there was involvement and the latter more likely to believe there was not - see Table 10.9 While this is not statistically significant it suggests important perceptual and power differences in the boardroom.

Table 10.9
Director Involvement in Identified Board Priorities by Aggregated Board Role

	Yes	No	Don't Know
n = 243	125 (51.4%)	109 (44.9%)	9 (3.7%)
Chairs/CEOs	27 (57.4%)	19 (40.4%)	1 (2.1%)
NEDs/Excts.	98 (50.0%)	90 (45.9%)	8 (4.1%)

Given the central importance of the Chair/CEO relationship (NHSTA,1987) in providing leadership within the board and to the organisation, 36.6% agreed that there was complete clarity about the boundary between the role of Chair/CEO, 48.7% thought there was only reasonable clarity and the remainder (14.8%) were less certain or did not know. While this represents a largely clear and unambiguous relationship for the majority, this was not the case for somewhat more than 1:8. Those who were least likely to agree, or who were simply uncertain, that there was clarity were Executives (20.3%) and NEDs (14.7%) - see Table 10.10.

Table 10.10
Role Clarity Between Chair and CEO by Board Role

	Complete Clarity	Reasonable Clarity	Little Clarity	No Clarity	Don't Know
n = 238	87 (36.6%)	116 (48.7%)	18 (7.6%)	3 (1.3%)	14 (5.9%)
Chairs	14 (60.9%)	8 (34.8%)	0	1 (4.3%)	0
NEDs	40 (36.7%)	53 (48.6%)	6 (5.5%)	0	10 (9.2%)
CEOs	9 (39.1%)	13 (56.5%)	1 (4.3)	0	0
Excts	24 (28.6%)	43 (51.2%)	11 (13.1%)	2 (2.4%)	4 (4.8%)

If these same data are analyzed from a slightly different viewpoint - see Table 10.11 - the difference of view

between the two sub groups has a Chi-squared value of 8.8526548 and is significant at the 10% level.

Table 10.11
Role Clarity Between Chair and CEO by Aggregated Board Role

	Complete Clarity	Reasonable Clarity	Little Clarity	No Clarity	Don't Know
n = 238	87 (36.6%)	116 (48.7%)	18 (7.6%)	3 (1.3)	14 (5.9%)
Chairs & CEOs	23 (50.0%)	21 (45.7%)	1 (2.2%)	1 (2.2%)	0
NEDs & Excts	64 (33.3%)	95 (49.5%)	17 (8.9%)	2 (1.0%)	14 (7.3%

Finally, given the personal nature of Chairmanship appointments and the (increasingly) "hands on" style that many adopt (HSJ,1993), is it possible for directors to challenge their Chair ? 40.3% suggest that this is always the case; 45.7% that this is mostly so - see Table 10.12.

Table 10.12
Ability of Executives and NEDs to Disagree with Chairs by Board Role

	Always	Mostly	Rarely	Not at all	Don't Know
n = 243	98 (40.3%)	111 (45.7%)	31 (12.8%)	1 (0.4%)	2 (0.8%)
Chairs	14 (60.9%)	8 (34.8%)	1 (4.3%)	0	0
NEDs	50 (45.0%)	43 (38.7%)	16 (14.4%)	1 (0.9%)	1 (0.9%)
CEOs	13 (54.2%)	10 (41.7%)	1 (4.2%)	0	0
Excts	21 (4.4%)	51 (59.3%)	13 (15.1%)	0	1 (1.2%)

This does suggest that there is little overall cause for concern and that it is unlikely that a Chair would be able to lead his or her board in a direction, or to become deeply embroiled in a particular project, that did not command general consent. Some respondents (14%) i.e. somewhat more than 1:8 were less certain. Those least likely to believe that Chairs could be challenged were Non-Executive directors/Executives who were almost four times more likely to hold such a view than Chairs/CEOs - see Table 10.13.

Table 10.13
Ability of Executives and NEDs to Disagree with Chairs by Aggregated Board Role

	Always	Mostly	Rarely	Not at all	Don't Know
n = 243	98 (40.3%)	111 (40.3%)	31 (12.8%)	1 (0.4%)	2 (0.8%)
Chairs & CEOs	27 (57.4%)	18 (38.3%)	2 (4.3%)	0	0
NEDs & Excts	71 (36.2%)	93 (47.4%)	29 (14.8%)	1 (0.5%)	2 (1.0%)

If these data are analyzed from such a viewpoint, the difference of view between the two sub groups has a Chi-squared value of 8.949601 and is significant at the 10% level.

10.5 Strategic Direction: Discussion

The notion of the board as central to, and the source of, organisational direction, is fundamental to almost all Western definitions of corporate governance. That said, the evidence from this study suggests some misalignment between clarity of purpose and the existence of a mission on the one hand and clearly articulated and understood values and accountabilities on the other. Hague (1993) has observed that an important distinction between the private and public sectors is, in the case of the latter, that its role is defined for it. In the period between the introduction of the post reform/new style District Health Authorities and the fieldwork for this study, however, this was not generally true in respect of the boards of NHS bodies. They therefore tended to vacillate between setting strategy and decision management i.e. between formulation and/or evaluation (Ashburner et al, 1994).

The publication in February 1994 of the Codes of Conduct and Accountability (DOH, 1994) unequivocally defined the role of a board in an NHS body - see **Fig 10.4** However, although the Code of Conduct (ibid) articulated accountability, probity and openness as "public service values", and the Code of Accountability identified a series of measures which constituted "statutory accountability" they had most significance on a service wide rather than local basis. It is important therefore for boards to define explicitly a wider set of operating values and

accountabilities, which are consistent with the national framework but have local salience. Indeed, given the cultural revolution which the new style boards both represent and lead, the assertion that:

> "since we are concerned with changing organisation culture, our main concern must be with the top of the organisation, where its tone is set"
>
> (Hague, 1993 p26)

is particularly apposite. Indeed, as Dixon (1993,p3) observes,

> "much of the current malaise and inefficiency in the private and public sectors arises from an unwillingness to clarify who is accountable for what to whom".

It is important therefore that boards regularly review the manner in which they work and address any shortfall. The fact that less than half of respondents reported any form of regular review of working style, also confirmed by Stern *et.al.* (1995), is a source of concern.

Fig 10.4 clearly identifies the importance of setting strategic direction, indeed, "it is widely accepted that Non-Executive directors should be involved in the development of the strategy, not rubber stamp a strategy already formulated by executive directors" (Audit Commission, 1995 p9). The findings from this study indicate that a narrow range of strategic issues have been identified and that there is little systematic involvement

of directors in these areas. This tends to resurrect earlier views of the nature, contribution and value of the Non-Executive director - this is very disappointing. Increasingly, however, health bodies will *have* to be effective as their environment becomes ever more demanding. The requirement to be 'competitive' is therefore not restricted to the private sector.

Fig 10.4
Functions of NHS Boards

NHS boards have six key functions for which they are held accountable by the NHS Executive on behalf of the Secretary of State:

1. to set strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them,

2. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary,

3. to ensure effective financial stewardship through value for money, financial control and financial planing and strategy,

4. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation,

5. to appoint, appraise and remunerate senior executives, and,

6. to ensure that there is effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

Source: (NHS Management Executive, 1994 p8-9)

Finally to relationships. The RSA's Inquiry *Tomorrow's Company* (Cleaver, 1995) emphasises the importance of relationships particularly, but not exclusively, between a Company and its outside stakeholders. The final element in exploring the nature of Strategic Direction concerns relationships within the board. The literature has classically illuminated the importance and complexity of the Chair/CEO relationship (e.g. Stewart, 1991). However, more recently the scandals in the West Midlands and Wessex RHAs have revealed another and more critical dimension to this central relationship. As in these instances, clearly things can and do go wrong e.g. when Chairs dominate management (Sheldon, 1993) - prompting guidelines for "difficult relationships" (Anon, 1994) - when the Chair/CEO axis marginalises Non-Executive directors (Williamson, 1994b), or, having been forced to resign, when an ex-Chair attempts to sue her former Non-Executive directors for libel (HSJ,1995)a.

It is important, therefore, to understand this relationship given its defining power in terms of boardroom climate, liberating or limiting the role played by directors and acting as the fulcrum upon which corporate governance is balanced. Respondents indicated - at least at face value - that there was clarity between the role of the Chair and that of the CEO, and, that the Chair could be challenged. Those who doubted this clarity (Executives and Non-Executive directors in that order) or the ability to

challenge/divert their Chair (Executives and Non-Executives in equal measure) tend to reinforce doubts about the Chair/CEO axis and the reality of boardroom power.

- Chapter 11 -

The Postal Survey: Executive Management

11.1 Introduction

This chapter will report further findings from the postal survey and - taking Tricker's model of corporate governance (Tricker, 1984) as a convenient framework - continue by looking at the sphere of **executive management.**

11.2 The Element of Executive Management in Corporate Governance

11.2.1 Tricker's Formulation A dominant influence in the literature is Tricker's model of corporate governance (Tricker, 1984; also Hilmer & Tricker, 1990). In its original form it consisted of four fields - Strategic Direction, Executive Management, Supervision and Accountability - this chapter is principally concerned with Executive Management.

Executive management is concerned with "the running of the business - shorter term operational matters of financial, production and market management, keeping an eye on performance throughout the enterprise and taking decisions consistent with the strategies" (Tricker, 1984 p175). In short this is the area of board activity which -

concerned as it is with planning, co-ordinating, motivating and leading - is closest to the management task.

11.1.2 Executive Management. Executive management is that dimension of corporate governance concerned with making decisions and taking action at the highest organisational level. An important aspect of this is the nature of the relationship between the Chairman and the CEO. Although the survey findings in this regard are set out in detail in Chapter 10, it is important to remember - in *this* regard - that there are differences in the views of Chairs/CEOs and Non-Executive directors/Executives concerning the distinction between the role of the Chair and the CEO - see Table 10.11 Such findings provide an important backdrop against which to consider the issues of who has access to the board's agenda, the nature and style of decision making and the differential contribution of directors.

When asked if Executive and Non-Executives had the opportunity of placing items on the board's agenda 63% replied that there was ample opportunity, 23.5% some opportunity, 9.5% few opportunities and 0.8% no opportunity; 2.5% did not know. Although the overall pattern remained unchanged, CEOs and Chairs held the most positive view and Non-Executive directors a somewhat less positive view, with some 1:5 doubting or being uncertain about their access to the board's agenda - see Table 11.1 This concurs with the findings from the pilot study.

Table 11.1 Access to Agenda by Board Role					
	~ Opportunities ~				
	Ample	**Some**	**Very Few**	**None**	**DK**
n = 243	155 (63.8%)	57 (23.5%)	23 (9.5%)	2 (0.8%)	6 (2.5%)
Chairs	17 (73.9%)	4 (17.4%)	2 (8.7%)	0	0
NEDs	59 (53.2%)	29 (26.1%)	16 (14.4%)	2 (1.8%)	5 (4.5%)
CEOs	19 (79.2%)	4 (16.7%)	1 (4.2%)	0	0
Excts	60 (69.8%)	21 (24.4%)	4 (4.7%)	0	1 (1.2%)

In terms of decision making 86.3% reported that consensus was the dominant mode, 10.8% reported voting and 2% diktat; 0.8% did not know. There was little perceptible difference by role. However, when these data are analyzed by tenure those most recently appointed are marginally less likely to report consensus in favour of diktat - see Table 11.2 When analyzed by gender, female board members were much more likely to report voting and diktat. The gender differences have a Chi-squared value of 7.8902895 and is significant at the 5% level - see Table 11.3

Table 11.2 Decision Making Style by Tenure				
	Diktat	**Voting**	**Consensus**	**Other**
n = 240	5 (2.1%)	26 (10.8%)	207 (86.3%)	2 (0.8%)
> 2 years	4 (4.9%)	9 (11.1%)	67 (82.7%)	1 (1.2%)
2-5 years	1 (0.8%)	13 (10.3%)	111 (88.1%)	1 (0.8%)
< 5 years	0	4 (12.5%)	28 (87.5%)	0

Table 11.3 Decision Making Style by Gender				
	Diktat	**Voting**	**Consensus**	**Other**
n = 239	5 (2.1%)	26 (10.9%)	206 (86.2%)	2 (0.8%)
Male	2 (1.1%)	15 (8.5%)	158 (89.8%)	1 (0.6%)
Female	3 (4.8%)	11 (17.5%)	48 (76.2%)	1 (1.6%)

Some two thirds of directors, overall, saw their contribution as being that of a generalist (63.3%), a third that of a specialist (33.8%) and the remainder, other (2.9%). When these data are analyzed by membership sub group i.e. Chairs/CEOs and Non-Executive directors/ Executives, the former see themselves exclusively as generalists with the remainder holding mixed specialist and generalist views. This role difference has a Chi-squared value of 32.946283 and is highly significant at the 1% level - see Table 11.4

Table 11.4 Contribution to the Board by Member Sub Group			
	Specialist	**Generalist**	**Other**
n = 240	81 (33.8%)	152 (63.3%)	7 (2.9%)
Chairs & CEOs	0	46 (100%)	0
NEDs & Excts	81 (41.8%)	106 (54.6%)	7 (3.6%)

Table 11.5 Contribution to the Board by Type of Executive			
	Specialist	**Generalist**	**Other**
n = 108	62 (57.4%)	43 (39.8%)	3 (2.8)
Chief Executive	0	23 (100%)	0
D of Finance	21 (84.0%)	4 (16.0%)	0
Director of Public Health	27 (84.4%)	5 (15.6%)	0
Director of Purchasing	8 (57.1%)	5 35.7%)	1 (7.1%)
Remaining Director	6 (42.9%)	6 (42.9%)	2 (14.3%)

Of those Executives who expressed a view as to thenature of their contribution, like the pilot study, Directors of Finance and Directors of Public Health were the most likely to see their contribution in "specialist" terms, as were directors of purchasing but to a lesser degree. The 'fifth place' directors had a somewhat more evenly balanced view. These differences between Executives have a Chi-squared value of 59.991363 and are highly significant at the 1% level - see Table 11.5

Whatever the perception of the nature of their contribution, when asked who made the most decisions 92% of respondents identified Executive directors.

11.3 Executive Management: Discussion

This is the sphere of board activity which is capable of being both straight forward and ambiguous at one and the same time. Whilst Tricker is very clear in his formulation - see 11.2.1 above - and the NHS Code of Accountability leaves little room for doubt:

> "the chief executive is directly accountable to the chairman and non-executive members of the board for the operation of the organisation and for implementing the board's decisions"
>
> (DOH, 1994 p8)

the reality is much less clear.

Part of the confusion and tension resides in the view of some Non-Executive directors that to be both independent and objective they should stand back from the day-to-day reality and thus avoid becoming compromised or 'tainted'. Indeed Williamson (1994, p23) comments that taken to extremes this "warns non-executives against involvement in management, and the warning appears to accord with non-executives' role as strategic thinker". Hamilton & Rumsey (1995, p24) helpfully contrast "the executive director as the person intimately involved... from the 'inside out' and the non-executive director as looking from the 'outside in'" They further observe:

> "Too much involvement in management will impinge on the work of the executive but too little will impoverish the capability of the board".
>
> (ibid)

Although such tensions can and do exist, the problem faced by some managements is, if anything, the reverse. Examples include the "hands on" nature of some chairmen (HSJ, 1993); the 'keep the Non-Executive directors busy' approach via "developing a degree of specialisation" or, in the case of purchasers "using non-executive directors to gain a better knowledge of their providers" (Audit Commission, 1995 p10); or, the complete migration of some Chairs/Non-Executive directors into full time management (Crail, 1994). The single greatest issue in regard to Executive Management in the boardroom is one of definition. This in turn delineates

the boundary between the role of the Executive and the Non-Executive allowing each to function effectively.

A central and defining feature of executive management is that of taking decisions. There are issues of style - which from the evidence of this study are overwhelmingly rooted in consensus - and issues of substance i.e. *what* is to be decided. Ham *et.al.* (1990, p33) suggest that boards "will have to decide what issues they wish to reserve for themselves, what issues should be delegated [and] how they intend to monitor progress...". Issues which NHS boards typically reserve unto themselves include, for example, the appointment and remuneration of the CEO and the Executive directors, issues of strategic direction, and, capital investment decisions over an agreed threshold.

However, debate can only take place and decisions follow if issues are placed on the board's agenda. The evidence from this study clearly concludes that this is not, overall, a problem. An important exception, however, is the extent to which women (particularly Non-Executive) directors feel this is truly the case. Their difficulties may arise from any one or a combination of three factors. Firstly, although the number of female directors is increasing, a significant proportion have only recently been appointed. They may therefore lack experience, boardroom craft or the sheer tenacity to drive an issue through to a conclusion. Where the female director is an

Executive, they are most likely to have sprung from a Nursing (or Therapy) background. As a consequence they may be viewed by their peers as having less status than the members of other professions, consequently having had less access to power and thus having poorer experience and lower self esteem. On all counts they are likely to be significantly disadvantaged in both absolute and relative terms. Finally, it may be that the "masculine culture" (Williamson, 1995) is, in some settings, simply too loud and brash and therefore overwhelms some female directors. Whatever the reason, the overall picture tends to support the notion that women have less access to power and policy influence than their male counter parts (CSO, 1995). If indeed this is the case, concentration upon the number of women in the boardroom rather than the *real* opportunities they have to contribute, may result in a misleading assessment of the extent of progress.

The focus of attention that NHS boards have received has tended to focus upon the size and nature of the boards together with the value and contribution of Non-Executive directors. Important as these factors certainly are they have tended to overlook the part played by Executives. Generally, it has been assumed that if managers know how to manage they must, almost automatically, know how to make the corporate contribution now required of them in the context of the new unitary boards. The evidence from this research - that only a third of Executives see themselves

playing a "generalist" role - clearly suggests this is not the case. Stern *et.al.* (1995, p13) reinforce this by asserting that "executives still tend to see themselves as senior managers rather than directors". This may arise from a 'gentlemen and players' attitude in some boards or from inadequate induction/development of Executive directors.

The debate within the Service and reflected in this discussion has centred upon some ambiguity as to where various actors stand *vis-a-vis* Executive Management; the extent to which women directors can impose themselves upon the resultant dynamic; and, the quality of the corporate role played by Executive directors. Whilst this latter issue has received rather less attention than it perhaps deserves, it has at least now broken the surface. Ironically, however, this has taken place against the backdrop of the Code of Accountability which states that the Chief Executive must be allowed "full scope in fulfilling the decisions of the board" (DOH, 1994 p10) and the notion that some boards might be in danger of deferring to "managerial freedom" in a manner analogous to earlier attitudes towards clinical freedom (Williamson, 1994 p22). Whilst managers must be allowed to manage and management and governance should not be confused, such developments do much to reinforce the differences rather than the similarities between Executive and Non-Executive directors. Taken to an extreme this may serve to undermine the unitary nature of the boards of NHS bodies.

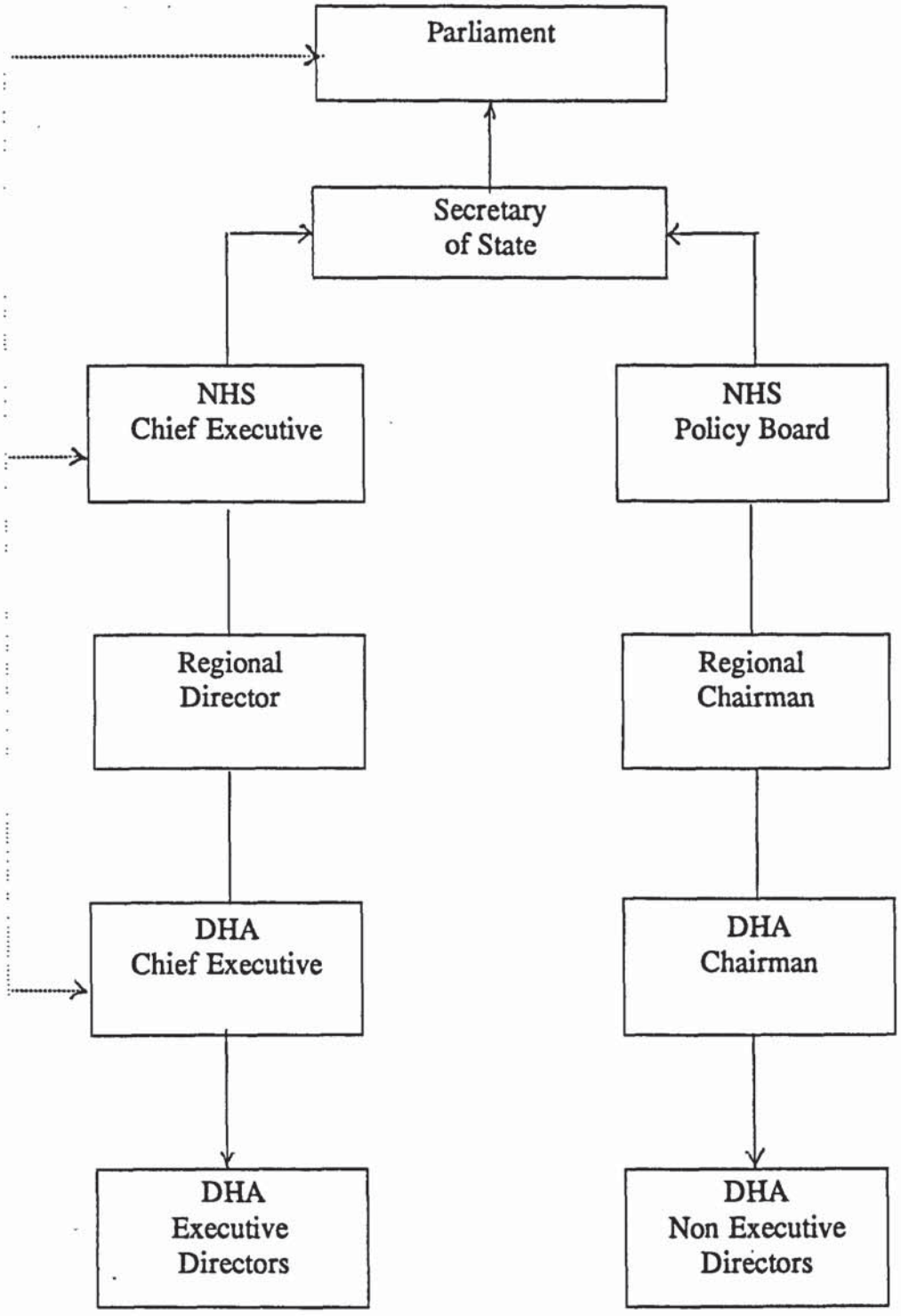
This may seem fanciful but the *primus inter pares* role of Chairmen could be seen to have received something of a challenge with the advent of the "accountable officer" initiative. This was announced in February 1995 and implemented two months later. It requires all Chief Executives of Health Authorities (and of FHSAs and of Trusts) to make a personal signed commitment to the Chief Executive of, and Accounting Officer for, the NHS. The initiative is designed to "strengthen the existing mechanisms for local and Parliamentary accountability" (Langlands, 1995) and, in particular, the accountability of the Chief Executive "for the use made of the public funds and assets they control" (BN, 5/95). Guidance is also provided "on what the Chief Executive should do if their board is considering a course of action which he/she, as the Accountable Officer, considers would infringe the strict requirements of propriety and regularity" (ibid).

This initiative - driven by the scandals explored in Chapter 4 and reinforcing the subsequently published Codes of Conduct and Accountability (DOH, 1994) - is, at face value, welcome. What it betrays, however, is some ambiguity on the part of the Government's attitude and position. Most of the guidance published to date has cast Chairmen in the publicly accountable role, and the Chair and Non-Executive directors in a clear supervisory relationship with Executive directors. This initiative appears to cast some doubt on this 'certainty' in so far as the Chief Executive

now has an explicit accountability relationship, via the NHS Management Executive, to Parliament; also the powers to act against his board if they appear to be about to act imprudently. Whilst these measures have an attractive and compelling logic they do, in the case of the former, appear to diminish the role of the Chair and, in the case of the latter, challenge the moral rectitude which normally attaches to the supervision of Executives by Non-Executive directors. This may simply be a reflection of confused thinking or a portent of a move away from unitary boards. Although the latter is not the declared view of Government it would be consistent with the separation of political and managerial accountability which appears to be developing - see **Fig 11.1** A move away from District Health Authority unitary boards is certainly consistent with Labour Party policy which seeks a:

> core management team, comprising the chief executive and other senior executives... to be accountable to a supervisory board of non-executive directors representing the community"
>
> (Labour Party, 1995)

Fig 11.1
A Rational and Political Separation of Powers in the NHS ?



- Chapter 12 -

The Postal Survey: Supervision

12.1 Introduction

This chapter will report further findings from the postal survey and - taking Tricker's model of corporate governance (Tricker, 1984) as a convenient framework - continue by looking at the sphere of **Supervision.**

12.2 The Element of Supervision in Corporate Governance

12.2.1 Tricker's Formulation A dominant influence in the literature is Tricker's model of corporate governance (Tricker, 1984; also Hilmer & Tricker, 1990). In its original form it consisted of four fields - Strategic Direction, Executive Management, Supervision and Accountability - this chapter is principally concerned with Supervision.

Supervision is concerned with monitoring executive action. This is to ensure that management action reflects the decisions taken by the board and that such action is consistent with the interests and expectations of those stakeholders who have a legitimate interest in the organisation. As Tricker (1984, p176) puts it, "supervision is an activity carried out to monitor and control management action".

12.2.2 Supervision

The supervisory dimension of corporate governance is central to ensuring that a board operates in a way which is beyond reproach. Arguably, if greater or more effective supervision had taken place many of the recent private and public sector scandals might have been averted.

When asked if consideration had been given to appointing a Company Secretary 40.8% replied that this was the case, 40.3% that it was not and 18.9% did not know. When the same data are analyzed by member group - see Table 12.1 - Chairs and CEOs were twice as likely to respond in the affirmative than Non-Executive directors and Executives, which has a Chi-squared value of 27.638375 and is highly significant at the 1% level. This would suggest that this matter was considered but at a high, rather than at board level.

Table 12.1
Consideration Given to the Appointment of a Company Secretary

	Yes	No	DK
n = 238	97 (40.8%)	96 (40.3%)	45 (18.9%)
Chairs and CEOs	34 (79.9%)	11 (23.9%)	1 (2.2%)
NEDs and Executives	63 (32.8%)	85 (44.3%)	44 (22.9%)

Leaving aside the role most closely associated with 'policing' the functioning of the board, the majority of the supervision of the executive is undertaken by the Chair

and the Non-Executive directors in the course of board proceedings and in and via the committees of the board. When asked to indicate the existence of committees of the board - see Table 12.2 - the most commonly reported was an audit committee (55.7%) followed by management review (20.7%) and remuneration (17.1%). Both audit and remuneration committees - despite being at opposite ends of the frequency continuum - were less in evidence than expected, although it should be noted that the survey was undertaken prior to the publication of the Codes of Conduct and Accountability (DOH, 1994). Of those who did report the existence of any form of committee 86.5% stated that all or most had a clear mandate, 5.7% that they did not; 6.4% did not know. The mere existence of a board committee is not in or of itself sufficient. Committees need to have a clear and understood role which was not the case for some 1:8 of respondents.

Table 12.2
The Existence of Board Sub Committees in DHAs

	Yes	No	DK
Base = 860	286 (33.3%)	497 (57.8)	77 (9.0%)
Audit	131 (55.7%)	91 (38.7%)	13 (5.5%)
Remuneration	37 (17.1%)	154 (71.3%)	25 (11.6%)
Management Review	44 (20.7%)	147 (69.0%)	22 (10.3%)
Other	74 (37.8%)	105 (53.6%)	17 (8.7%)

The majority of respondents (79.1%) indicated that the

information provided to the board supported monitoring and control completely or to a reasonable degree; the remainder (20.9%) to a limited degree, not at all or they did not know. While this represents a high level of achievement, the quality of information provided to board members challenges the ability of 1:5 to engage in effective supervision. A closer analysis reveals that this is a particular problem for Non-Executive directors and Executives - see Table 12.3. Despite this, 92% report that the atmosphere in the boardroom is such as to permit frank discussion or to challenge assumptions, always (46.6%), mostly (45.4%), rarely (7.1%), not at all (0.4%) or they did not know (0.4%). This is supported by access to the board agenda by the majority. As noted on Chapter 11, however, this was not the experience for some 1:5 NEDs.

Table 12.3
The Extent to which Information Provided to Board Members Supports Monitoring and Strategic Control

	Chairs	NEDs	CEOs	Excts
n = 239	23 (100%)	109 (100%)	24 (100%)	84 (100%)
Completely	5 (21.7%)	12 (11.0%)	3 (12.5%)	6 (7.1%)
To a reasonable degree	15 (65.2%)	71 (65.1%)	19 (79.2%)	58 (69.0%)
To a limited degree	1 (4.3%)	22 (20.2%)	1 (4.2%)	17 (20.2%)
Not at all	1 (4.3%)	1 (0.9%)	1 (4.2%)	2 (2.4%)
Don't know	1 (4.3%)	3 (2.8%)	0	1 (1.2%)

The net product of much of a board's activity is to mandate others, usually the executive, to take action on its behalf. It would seem prudent therefore for a board to satisfy itself that the agreed action *has* been taken i.e. been implemented. When, however, respondents were asked if their board had such a mechanism 56.3% stated it had, 32.1% that it had not and 11.7% did not know. Further analysis by member type - see Table 12.4 - indicates some important differences between Non-Executive directors and other members of the board, with half of the former denying or being ignorant of any implementation scrutiny. In the light of these findings one might ask, what price independent supervision ?

Table 12.4
Existence of a Review Mechanism to Ensure Implementation

	Chairs	NEDs	CEOs	Excts
n = 240	23 (100%)	109 (100%)	24 (100%)	85 (100%)
Yes	15 (65.2%)	54 (49.5%)	16 (66.7%)	50 (58.8%)
No	6 (26.1%)	34 (31.2%)	8 (33.3%)	30 (35.3%)
Don't Know	2 (8.7%)	21 (19.3%)	0	5 (5.9%)

If the Company Secretary - as an important symbol of supervision - is not a common phenomenon and the supervisory opportunities for some board members is seen by them as a variable experience, what of the performance of individuals ? To what extent is the performance of the

individuals, as opposed to the tasks upon which they are engaged, the subject of scrutiny ? When asked if the Chair reviewed the contribution of Non-Executive directors on a regular basis 36.6% of respondents replied that this was the case - see **Fig 12.1** A more detailed analysis, however, suggests that the views of Chairs (and their CEOs) are at variance with experience/knowledge of the Non-Executive directors themselves - see Table 12.5 - which has a Chi-squared value of 48.781224 and is highly significant at the 1% level.

Table 12.5
Review of Non Executive Directors by Chair

	Chairs	NEDs	CEOs	Excts
n = 238	23 (100%)	109 (100%)	23 (100%)	84 (100%)
Yes	17 (73.9%)	31 (28.4%)	18 (78.3%)	21 (25.0%)
No	5 (21.75)	35 (32.1%)	5 (21.7%)	18 (21.4%)
Don't Know	1 (4.3%)	43 (39.4%)	0	45 (53.6%)

When asked if Chairs and Non-Executive directors reviewed executive directors, only 15.4% indicated that this was the case - see **Fig 12.2** Further analysis is shown at Table 12.6, which has a Chi-squared value of 19.796736 and is again highly significant at the 1% level. Indeed only 14% overall of CEOs and Executives confirm that this is the case. The findings in terms of explicit supervision are both surprising and disturbing. It would appear - although some Non-Executive directors challenged the view -

Fig 12.1
The Review of Non Executive Directors
by the Authority Chair

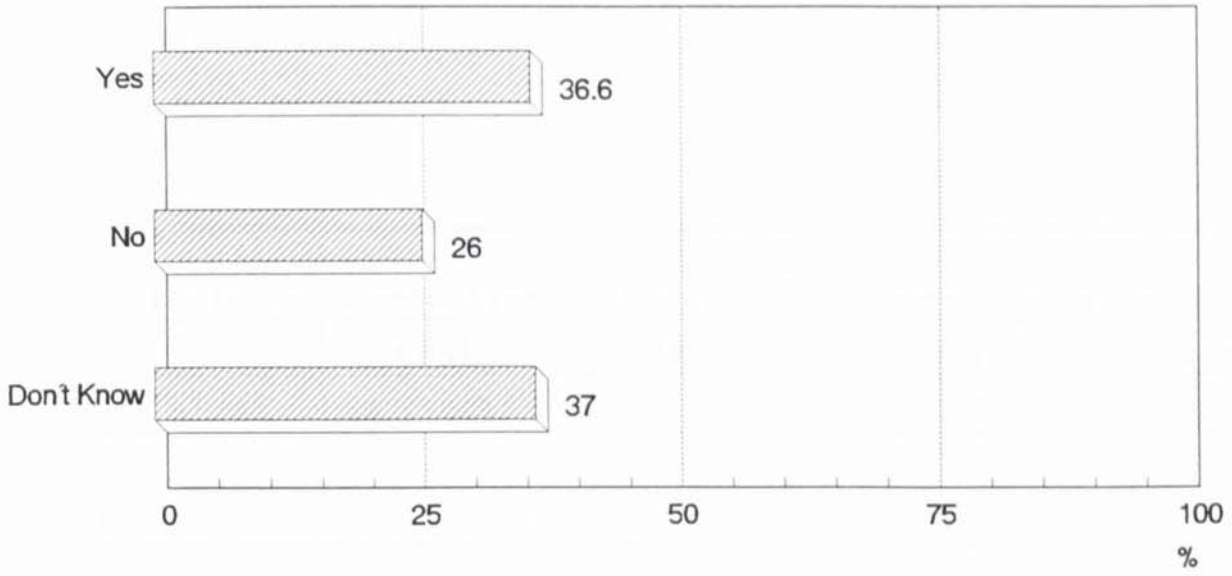
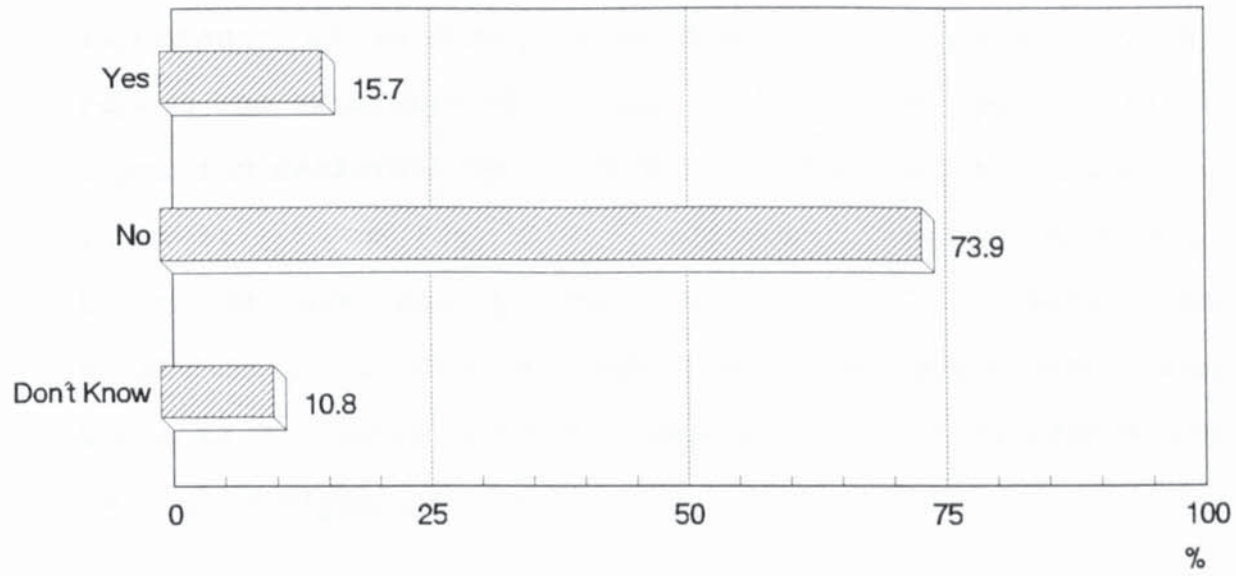


Fig 12.2
The Review of Executives by Authority
Chair and Non-Executive Directors



that Non-Executive directors are twice as likely to have their performance reviewed as Executives. The issue is not that this takes place, but that the relatively low level is twice that for Executives who, 92% of respondents agree, make most decisions.

Table 12.6
Review of Executives by Chair & Non Executive Directors

	Chair	NEDs	CEOs	Excts
n = 241	22 (100%)	111 (100%)	21 (100%)	85 (100%)
Yes	4 (18.2%)	18 (16.2%)	4 (16.7%)	11 (12.9%)
No	18 (81.8%)	86 (77.5%)	20 (83.3%)	55 (64.7%)
Don't Know	0	7 (6.3%)	0	19 (22.4%)

Finally, although the majority (98.8%) support the importance of behaving ethically, only a third (32.5%) report the existence of a local ethical code; despite 33.9% reporting declarations of pecuniary or material conflict of interest - see **Fig 12.3.** Curiously, Chairs and Non-Executive are nearly twice as likely to report the existence of an ethical code than other directors - see Table 12.7 - which has a Chi-squared value of 22.358558 and is highly significant at the 1% level.

Fig 12.3
Measures of Ethical Orientation and
Behaviour in District Health Authorities

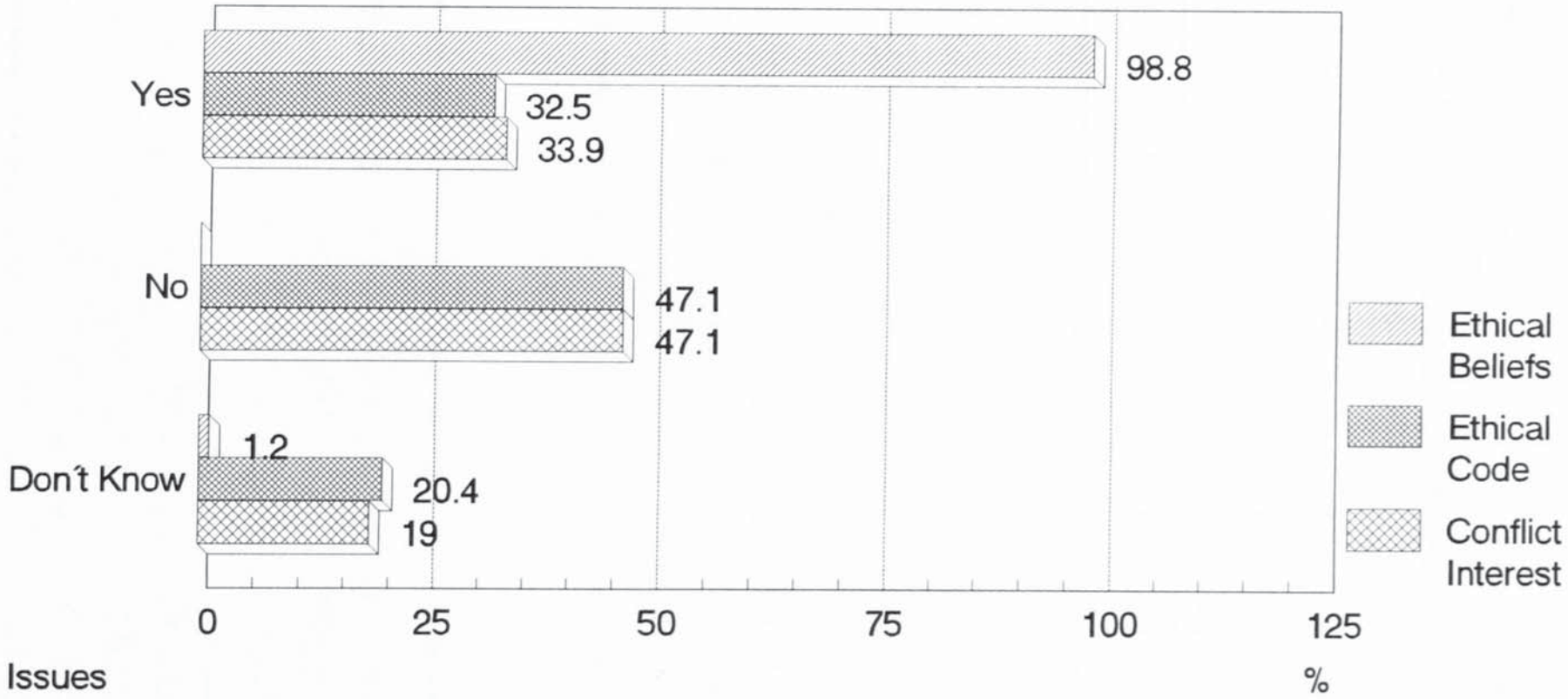


Table 12.7 Existence of an Ethical Code in DHAs		
	Chairs & NEDs	**CEOs & Excts.**
n = 240	130 (100%)	110 (100%)
Yes	53 (40.8%)	25 (22.7%)
No	43 (33.1%)	70 (63.6%)
Don't Know	34 (26.2%)	15 (13.6%)

Conversely CEOs and Executives are more likely to report conflicts of interest than other directors - see Table 12.8 - which has a Chi-squared value of 8.2703181 and significant at the 5% level. There is no obvious explanation for these differences other than the former perhaps represents a level of aspiration which is at odds with objective reality and is consequently reflected in the latter.

Table 12.8 Declared Conflicts of Pecuniary or Material Interest		
	Chairs & NEDs	**CEOs & Excts**
n = 242	132 (100%)	110 (100%)
Yes	36 (27.3%)	46 (41.8%)
No	73 (55.3%)	41 (37.3)
Don't Know	23 (17.4%)	23 (20.9%)

12.3 Discussion

The concept of **the Company Secretary** has existed for some considerable time and is a requirement of the Companies Acts 1985, section 283, and is therefore a common feature upon the private sector landscape. In such a context the role is generally well understood and well documented (see e.g. Walmsley, 1992 pB4/1). The publication, however, in December 1992 of The Report of the Committee on The Financial Aspects of Corporate Governance [Cadbury Report] gave a powerful endorsement to the role:

> "The company secretary has a key role to play in ensuring that board procedures are both followed and regularly reviewed. The chairman and the board will look to the company secretary for guidance on what their responsibilities are under the rules and regulations to which they are subject and on how those responsibilities should be discharged."
>
> (Cadbury, 1992 p25)

Indeed this occurred in a period when the public sector generally, and the NHS in particular, was becoming increasingly concerned about the performance of boards and the conduct of their directors in the wake of a number of well publicised scandals - see Chapter 4. In response to these circumstances the Secretary of State established the NHS Corporate Governance Task Force which published its findings in the Spring of 1994 (Shaw *et.al.*, 1994). This was subsequently followed by the publication the Codes of Conduct and Accountability (DOH, 1994).

It was widely assumed that the Task Force would endorse the Company Secretary role given that both the Task Force's creation and thinking had been substantially influenced by the Cadbury Report. Somewhat against expectation the Task Force concluded:

> "We are not, however, convinced that a post solely concerned with the functioning of an NHS board is necessary. Indeed, there are considerable dangers that this post holder will be seen as the upholder of the public service values we have said should lie at the heart of the way business is done in the NHS. That responsibility is the board's..."
>
> (Shaw *et.al.*, 1994 p31)

Despite the expression of contrary views (e.g. Stockmarr, 1994) this position was reinforced in the Code of Conduct in the following terms,

> "Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all board members."
>
> (DOH, 1994 p3)

Despite this unequivocal view, many boards of NHS bodies have and continue to adopt the near identical role of Secretary to the Board. Numerous appointments had been made prior to the Task Force report - a trend which has continued - in Trust, DHA and Health Commission setting(s).

During the course of the research reported herein, the job descriptions for such posts were obtained for ten vacancies which were advertised nationally between November 1993 and August 1995. This was done on an entirely opportunistic basis and the view which follows is therefore an impression of the nature and contribution of such posts rather than a robust and representative analysis. Vellenoweth (1994) offers guidance concerning The Company Secretary in the NHS, in particular by identifying the duties of such a role:

* to provide legal and administrative support;
* to support the implementation of corporate strategies by ensuring that the board's decisions and instructions are properly carried out and communicated;
* to ensure that the organisation abides by statutory and regulatory requirements;
* to communicate with stakeholders, and,
* to ensure that due regard is paid to their interests

before going on to interpret these in the context of the NHS. These five categories were used as the basis of the analysis of the ten job descriptions obtained during the period - see **Fig 12.4**

From this analysis we can clearly see that all but two were from Trusts. For the most part all of the job descriptions addressed the categories advanced by

Fig 12.4
Analysis of 'Secretary to the Board' Posts Advertised Nationally 1993-95

Organisation/Date Advertised	Trust A 11/93	Trust B 11/93	Trust C 12/93	Trust D 12/93	Trust E 3/94	Trust F 3/95	Trust G 4/95	H Com A. 5/9	Trust H 6/95	H Com B. 8/95
Role Dimension										
Legal and administrative support	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Support implementation of corporate strategy	No	No	Yes	No	No	No	No	No	Yes	Yes
Compliance with stat/legal standards	Yes	Yes	Yes	Yes	Yes	Yes	?	Yes	Yes	Yes
Communication with stakeholders	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Protecting stakeholder interests	No JD made explicit reference to this dimension - the focus was largely inward looking and defensive. Compliance with the remaining dimensions, however, may implicitly protect the wider (stakeholder) interest ?									
Other Duties	HQ Admin. Risk Mangt; Insur.	PR & HQ Admin.	Commu nication	Compl-aints		P/t post		Register of Interests HQ Admin.	Register of Interests General Admin.	Register of Interests HQ Admin.
Remuneration					£28K	SMP 21	£27K		£25-30K	£26K

Vellenoweth (1994) - apart from, with some exceptions, the dimension concerned with the implementation of corporate strategies. This is entirely consistent with the evidence from this study - see 12.2.2 above. All but one of the posts was full time and typically the remuneration was in the region of £25,000-30,000 per annum. Additional responsibilities often included dealing with risk management, insurance and complaints; also servicing Audit and other board committees and maintaining a register of member interests[1] (in respect of those jobs advertised after the publication of the Corporate Governance Task Force report). Where the role was seen to be combined with 'other' duties these most commonly involved public relations or headquarters administration. The quality of the job descriptions varied considerably. Ironically, those job descriptions which were most clearly thought through and thoughtfully expressed were less likely to need such a post than those boards who saw the role as little more than a middle ranking administrator.

Turning now to **the information needs of directors**, the survey findings clearly demonstrate that the majority of directors feel they are provided with sufficient information to support monitoring and control. However, 1:5 did not share this view.Why is this and what can be done ? Morrison (1971, p68) highlights some of the difficulties:

---

[1] Crail (1994), however, reports that RHAs were somewhat tardy in actioning this matter.

* outside board members do not share a common background of knowledge or sophistication;

* outside board members are part-time rather than full-time executives;

* outside directors often see only the tip of the iceberg

all of which are relevant to the NHS today. An obvious starting point is to be clear about the purpose for which a board requires information. Carver (1990, p18) suggests, broadly, that boards require "decision information, monitoring information and incidental information". Cowen & Osborne (1993) develop and expand this further by proposing that information is required for:

* financial analysis

* productivity management

* marketplace intelligence

* trends management, and,

* executive evaluation

confirming that "adequate information is a core requirement if directors are to perform satisfactorily". Morrison (1971) is very clear and somewhat more precise - a board's information should allow it to do five things:

* examine the underlying health of the organisation;

* gain an understanding of the present and future environment and the likely impact of the latter upon the organisation;

* establish the adequacy and validity of the organisations objectives;

* ensure the long term allocation of resources is sound, and,

* evaluate key executives.

Although it may be thought that such precepts are inappropriate in a health care setting this is not the case. The Audit Commission (1995, p20) point to the need for boards to decide what performance information they need and at what frequency. Typically a District Health Authority board considers 8-10 different types of information - see **Fig 12.5** Priestley *et.al.* (1995, p397) suggest - as above - these would be concerned with taking decisions, judging progress and judging the executive.

Fig 12.5
DHA Corporate Performance Reports

1. Major Public Health reports concerning the health of the local population/Health of the Nation indicators.
2. In-patient and out-patient waiting list reports
3. Waiting times in out-patient clinics - against contract or Charter standards
4. Reports upon Patients Charter matters
5. Contractual performance and activity
6. Extra Contractual Referral (ECR) reports
7. Day case performance reports
8. Efficiency reports
9. Financial performance including revenue, contracts position and cash flow.

Source: adapted from Priestley, Ritchie & Raynor (1995)

Given that a fifth of those surveyed in this study felt that they had inadequate information, it is important that steps are taken to improve the quantity and quality of information, particularly to Non-Executive directors and Executives. The Audit Commission (1995) identify five "hallmarks" of financial reports:

* summaries of finance and activity should be presented together;
* these should be supported by a short written explanation;
* projections should be included;
* comparisons made, and,
* a summary should be provided.

Priestley *et.al.* (1995, p398) advocate that such 'good practice' standards should be applied to all information and emphasise the need to present strategic and operational information in such a way that it can be "readily deduced" (ibid). Information should be provided regularly and the maximum use made of graphics and time series.

Although District Health Authorities often had **committees**, it was the publication of the Code of Accountability which formalised a requirement to:

> "establish audit and remuneration committees on the basis of formally agreed terms of reference which set out the membership of the sub-committee, the limit of their powers, and arrangements for reporting back to the main board."
>
> (DOH, 1994 p9)

Benson (1991, pC11/18) reminds us that audit committees have their origins in:

> "concern over the number of companies where executive management was perceived as exercising an unhealthily strong influence over the decision-making process, to the detriment of shareholders."

and so it proved in the public sector (see Chapter 4). Although only circa 56% of respondents reported the existence of an audit committee they were nearly three times more likely to exist than either a remuneration or management review committee.

Guidance published in the wake of the Code of Conduct and Accountability identified the role of the audit committee. In essence it was to promote and embody effective internal control, to be a focus for independent and objective review, and, to generalise their *raison d'etre* throughout the organisation (EL(94)38 p27). The Audit Commission (1995, p12) underline this and the relationship between the Non-Executive director and the auditors:

> "members of the audit committee have access to a unique independent view of, and judgement on, their organisation - that of the external auditor. Audit committees provide an opportunity for regular meetings between non-executive directors and auditors in a relatively informal setting. Issues can be covered in more depth and good working relationships developed. The value of this independent view is that auditors can identify for non-executive directors problem areas where action can be taken."

Of course the advent of the audit committee has given rise to both advantages and disadvantages - see **Fig 12.6**

Fig 12.6
Claimed Advantages and Disadvantages of Audit Committees

Advantages	Disadvantages
1. Assists directors in their legal obligations.	1. Causes dissent within the board.
2. Consolidates role of Non-Executive directors.	2. Powerless to enforce recommendations.
3. Strengthen audit independence.	3. Impractical because of lack of NEDs and does not decrease auditors responsibility.
4. Encourages higher quality auditing.	4. Too time consuming.
5. Improves contact between auditors, directors and management.	5. Pre-empts management responsibility.
6. Increases public confidence in the credibility and objectivity of the published financial information.	6. Increase in public confidence not proven.

Source: Gutherie & Turnbull (1995, p80)

Whilst large scale problems have not occurred within the NHS, experience to date has centred around two areas. Firstly, some audit committees, although not pursuing an overtly independent line do appear to enjoy a 'separated' existence. This has caused tensions between NEDs and executives and between the audit committee and non audit committee directors. Secondly, and largely as a consequence

of the numerous scandals, Government has put its full weight behind the creation and development of audit committees. So much so that the NHS Executive sponsored a national conference for the chairmen of NHS audit committees (HSJ, 1995)b. While at face value this was a welcome initiative, it has tended to fuel suspicion in some quarters that audit committees may almost become a 'state within a state'. Time will tell.

Carver (1990, p76) says of evaluation that it "should ideally be a precise, systematic, non intrusive, criteria-focused method that constantly answers the question 'How are we doing ?'" As we have seen, supervision is less clear cut in real life. In describing the role of the CEO, the Code of Accountability (DOH, 1994 p8) states that he or she is "directly accountable to the chairman and the non executive members of the board for the operation of the organisation and for *implementing the board's decisions*" [authors emphasis]. Ensuring **effective implementation** is therefore central to the notion of supervision.

The Audit Commission (1995, p14) talk in general terms about the contribution of Non-Executive directors and the case for the "naive question". However, they extend and develop this 'behaviourial' dimension in terms of the need for "a robust review of performance and follow-up of decisions" (ibid). In the case of the former, although they recognise the potential for conflict, they warn against

relationships becoming "too cosy" since this would diminish a Non-Executive directors objectivity and degrade their "constructive scepticism" (ibid). In the case of the latter, they observe:

> "Boards tend to focus on new business every month, with much less time (sometimes none) devoted to following up the implementation of previous decisions."
>
> (ibid, p17)

The findings from this study clearly show that this is a major area of weakness, with only a little over half of respondents reporting that their board explicitly satisfied itself that the implementation of earlier decisions had taken place. Stern *et.al.* (1995, p22) also reports that "the overall impression from directors is that few Boards have engaged in regular reviews of their effectiveness". Why should this be ?

The picture to emerge seems to suggest that boards spend much time and energy looking to the future whilst operating in the present, but little in looking back. This may be due to a mixture of factors. Firstly, many boards regularly engage in 'away days' or 'strategic retreats' and some directors may feel that the reflection which is so often a feature of such an experience is a sufficient acknowledgement of the past/earlier decisions. However, if such events - as many do - are concerned with the future, the past may simply be overlooked. If the past *is*

considered, it may only be as a general backdrop to the development of future strategy. Another major difficulty may be the nature or wording of an earlier decision; it may be so woolly as to defy a precise review of its implementation. As Fitzgerald *et.al.* (1993, p25) remind us, it is "important for the board to build criteria and performance standards into key objectives" (and important decisions). In terms of reviewing people rather than what they do, the study's findings suggest that Non-Executive directors are more likely to have their performance reviewed than are the Executive directors.

Whilst not wishing to be prissy about process or to be unnecessarily unrealistic, standards of supervision are clearly capable of further improvement. The simple truth is that almost all of the public sector scandals were rooted in assumption rather than evidence that things were generally 'on track', a failure to confirm that decisions had been fully implemented and a belief that the executive were competent. Such was and remains the reality of supervision.

Finally, to a consideration of the **ethical dimension** of corporate governance - which can be thought of in terms of governing principles, corporate values and personal morality (Lynch, 1994 p167). Since its inception, all those concerned with the NHS have talked wistfully about 'its values' but it is only comparatively recently that these

have been explicitly stated; for the public sector - see **Fig 12.7** - and, for the NHS, as accountability, probity and openness (DOH, 1994 p2). Despite the comparative 'youth' of these principles, most NHS boards have an appreciation of an appropriate value set and can differentiate them from those which apply in the private sector. The 'trick', however, is in either using such a value set as a backdrop, or, converting it to an ethical statement appropriate to the circumstances of a given organisation.

Fig 12.7
The Seven Principles of Public Life

Selflessness Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or friends.

Integrity Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership Holders of public should promote and support these principles by leadership and example.

Sources: Cm 2850-1 (1995, p14)

A recent survey by the Ethics Research Centre in Washington, DC, found that three fifths of American firms and about half of Europe's biggest companies now have a code of ethics (Anon, 1995b, p611). In terms of this study, the findings point to:

* support for the notion of behaving ethically (98.8%),
* the existence of a mission statement which reflects the values used by the Authority as the basis of its judgements (79.1%), but,
* an ethical code in less than a third of District Health Authorities

which suggests that District Health Authorities have either a mixed or a confused position, but, in either event, have some way to go in developing a more robust articulation of their values/ethical stance. This is not unimportant. Lilley (1992, p39) points out that "the mission statement may be supported with some 'value statements' [which] signal a position on issues". Examples of such issues include e.g. attitudes to patients, the environment or the management of assets which "explicitly lets everyone know the direction in which the [organisation] is going" (ibid). The mission statement and the value/ethical code are more than contemporary *chic*. They are clear statements to those within the organisation about *what* matters and *how* such goals are to be pursued. Furthermore they signal to the organisation's stake holders the way in which the organisation conducts itself - in the case of the NHS - on

their behalf. It is the governing principles and the corporate values which set the tone for the individual expression of personal morality.

In their survey on attitudes to probity and honesty amongst NHS board members, West & Sheaff (1994) found that the third most important and the first most difficult ethical issue was concerned with conflicts of interest/personal gain. The findings from this study found that 33.9% of respondents reported the declaration of pecuniary or material conflicts of interest. This was slightly less likely to be the case for Chairs/Non-Executive directors than for CEOs/Executives which may be explained by the assertion that "chairs were the most vigorous in their views, and executives the most permissive" (West & Sheaff, 1994 p29). The Code of Conduct (DOH, 1994 p4) clearly articulates the need for impartiality and therefore:

> "Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and entered into a register which is available to the public."

This position was subsequently vigorously reinforced by the Nolan Committee:

> "We take propriety to encompass not only financial rectitude, but a sense of the values and behaviour appropriate to the public sector".
>
> (Cm 2850-1, 1995 p82)

The register, however, is only the first step,

> "It is the guidance, and the seriousness with which we take it, and indeed seek to revise it ourselves when we consider it not tough enough, that will make the public feel confident we are doing the job in the public interest - or not."
>
> (Neuberger, 1995 p17)

However, as we have seen, West & Sheaff (1994) suggest that those with previous NHS work experience and serving Executives were the "most permissive" in respect of their attitudes. This suggests that an ethical standard is rather more relative than absolute. Indeed Lynch (1994, p115) suggests there is a relationship between the quality of goods/services and the elasticity of ethical behaviour - see **Fig 12.8**

If this is so, and the board is, in effect, the role model for organisational rectitude it is essential that they reflect the governing principles, articulate corporate values and personify personal morality. Lynch (1994, p169) proposes that legality, equity, social legitimacy, justification, confidentiality and sincerity are the "pillars of integrity". If an organisation doubts its credentials, it should undertake an integrity analysis (ibid p199) and take appropriate corrective action.

This discussion has sought to explore those dimensions associated with the role of secretary to the board role, the information directors need and receive, the committee

Fig 12.8
The Integrity-Quality Map
(Source: Lynch, 1994 p115)

environment within which they operate; also the extent to which they test management, review the implementation of decisions, review the performance of directors, and, the extent to which directors operate within ethical constructs. The picture to emerge reveals the complexity facing a director of a Health Authority in discharging their corporate governance obligations in respect of supervision.

- Chapter 13 -

The Postal Survey: Accountability

13.1 Introduction

This chapter will report further findings from the postal survey and - taking Tricker's model of corporate governance (Tricker, 1984) as a convenient framework - continue by looking at the sphere of **Accountability.**

13.2 The Element of Accountability in Corporate Governance

13.2.1 Tricker's Formulation A dominant influence in the literature is Tricker's model of corporate governance (Tricker, 1984; also Hilmer & Tricker, 1990). In its original form it consisted of four fields - Strategic Direction, Executive Management, Supervision and Accountability - this chapter is principally concerned with Accountability.

Accountability is concerned with "the response to legitimate demands for accountability from shareholders and other legitimate interests..." (Tricker, 1984 p176). Accountability involves both *giving an account* and being *held to account* and, although the balance and emphasis may differ, it is a phenomenon found in both the private and public sectors.

13.2.2 Accountability

As noted in Chapter 10 strongly affirmative responses were received when respondents were asked if their Authority had discussed its purpose (87.9%) and defined its role (77.2%). Surprisingly perhaps, only 18.6% stated that there was a very clearly defined sense of corporate identity. In terms of the balance, although the largest group overall felt corporate identity was reasonably well defined (58.6%), those who felt it was poorly or not defined at all[1], or simply did not know, represented almost 1:4 board members. When purpose and corporate identity are cross tabulated - see Table 13.1 - the relationship becomes clearer and with a Chi-squared value of 34.86403 is highly significant at the 1% level. The importance of these matters is central to questions of direction, but, also to the coherent development of a board and to the emergence of notions of 'self'. As has been noted elsewhere (Piaget, 1952) notions of self are an essential precursor to relationships - ultimately mature and balanced relationships - with others.

The majority of respondents reported the existence of a mission statement (84.6%), but the level of response fell sharply when they were asked if this included to whom and for what the Authority would be held accountable - see **Fig 13.1** Although encouraging to a degree, references to

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[1] Of the seven who reported that no corporate identity existed, all were Executives and four of the seven Directors of Finance.

accountability tended to be very broadly based and couched in terms of "the local population".

Table 13.1
The Relationship of Corporate Identity to a Discussed & Agreed Statement of Purpose

	Statement of Purpose		
	Yes	No	Don't Know
n = 234	207 (100%)	18 (100%)	9 (100%)
Corporate Identity			
Very clearly defined	43 (20.8%)	1 (5.6%)	0
Reasonably defined	123 (59.4%)	9 (50.0%)	5 (55.6%)
Poorly defined	35 (16.9%)	7 (38.9%)	3 (33.3%)
Not defined	6 (2.9%)	1 (5.6%)	0
Don't know	0	0	1 (11.1%)

More specifically, when asked if the Authority had agreed and published statements as to how it would wish to behave towards important stakeholders some considerable variability can be observed - see **Fig 13.2** Here we can observe that, surprisingly, only a little more than half (54.5%) report some agreed and published position in respect of the public and less than half in respect of providers (41.9%) and their own employees (48.7%). The

Fig 13.1
The Relationship of Purpose and Mission
to Values and Acountability

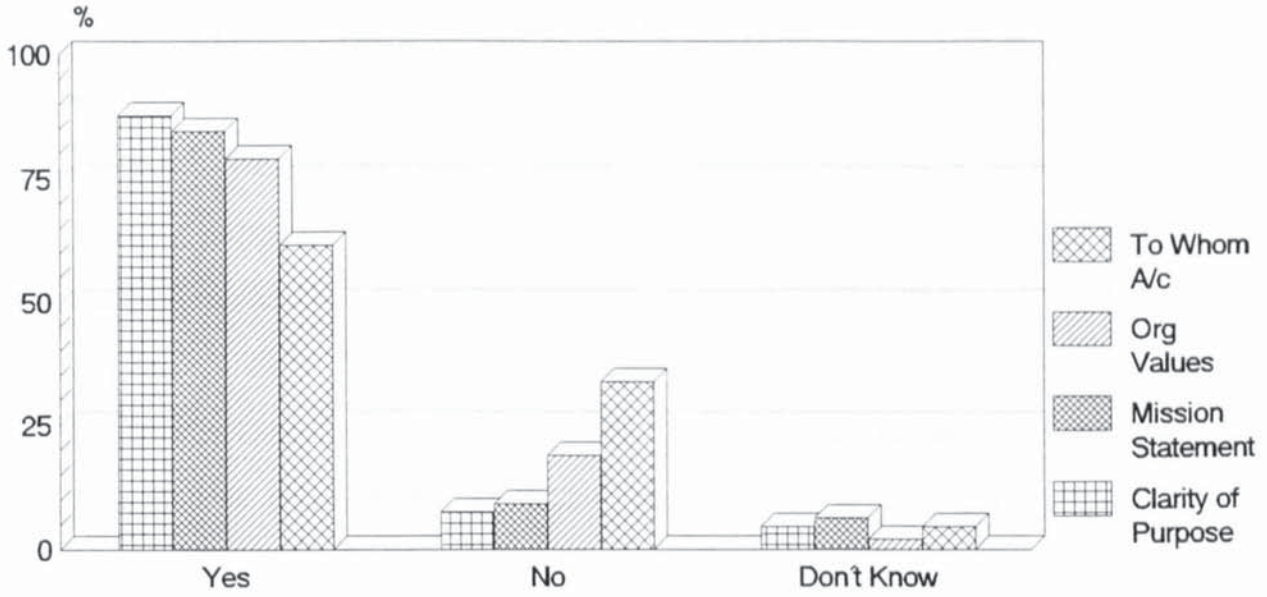
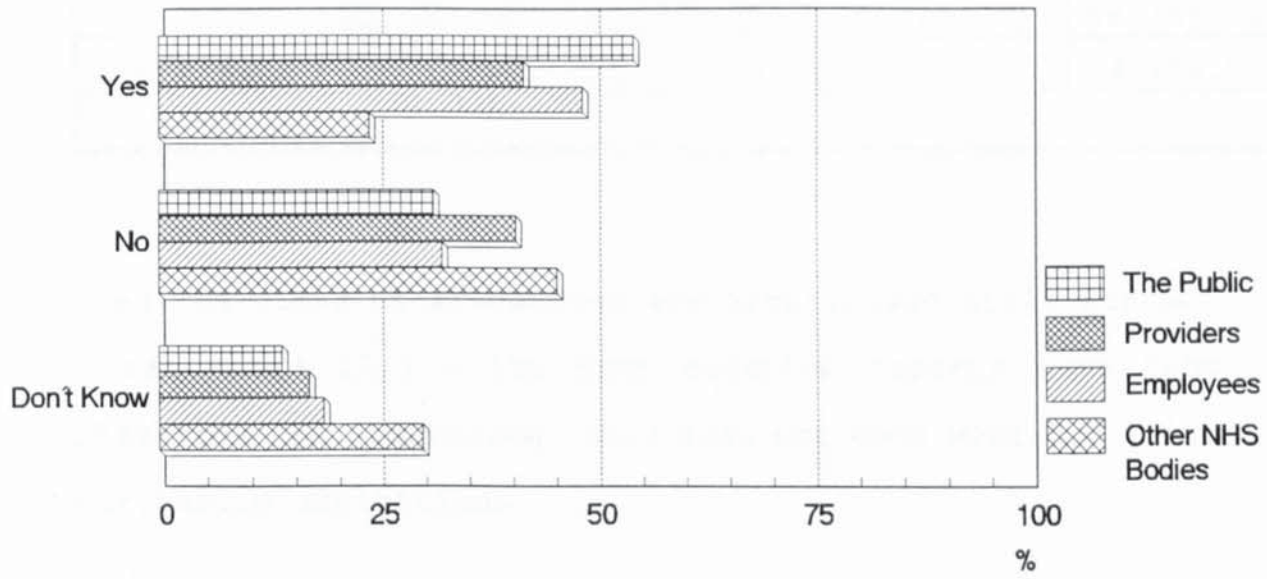


Fig 13.2
Explicit Posture
in Respect of Key Stake Holders



lowest single indicator is in terms of other NHS bodies (24.1%) which is surprising given the popularity of purchasing consortia and exhortations in recent years to work ever more closely with FHSAs. A further analysis in respect of other NHS bodies by director role - see Table 13.2 - appears to suggest little appetite for collateral relationships, particularly amongst Executives of all types, which has a Chi-squared value of 54.443432 and is highly significant at the 1% level. The knowledge of Non-Executive directors in this regard is particularly poor.

Table 13.2
Existence of An Agreed or Published Statement Concerning Relations Between DHAs and Other NHS Bodies

	Chairs	NEDs	CEOs	Excts
n = 232	22 (100%)	104 (100%)	23 (100%0	84 (100%)
Yes	8 (36.4%)	27 (26.0%)	7 (30.4%)	14 (16.7%)
No	11 (50.0%)	24 (23.1%)	16 (69.6%)	56 (66.7%)
Don't Know	3 (13.6%)	53 (51.0%)	0	14 (16.7%)

When the views of Executives are scrutinised still further - see Table 13.3 - the most negative reports come from Directors' of Purchasing. This does not bode well for joint purchasing aspirations.

Table 13.3
Existence of An Agreed or Published Statement Concerning Relations Between DHAs and Other NHS Bodies by Executive Role

	Director of Finance	Director of Pub Hlth	Director of Purch	Other
n = 83	25 (100%)	31 (100%)	13 (100%)	14 (100%)
Yes	5 (20.0%)	5 (16.1%)	3 (23.1%)	2 (14.3%)
No	17 (68.0%)	20 (64.5%)	10 (76.9%)	8 (57.1%)
DK	3 (12.0%)	6 (19.4%)	0	4 (28.6%)

Having considered issues of purpose, corporate identity and posture towards key stakeholders, how and to what extent do Authorities, explicitly, demonstrate accountability ? The reported frequency of public meetings of Authorities is a critical indicator - see **Fig 13.3** In comparison with the pilot study the data clearly demonstrate a move back towards greater transparency, although two thirds still meet less frequently than pre reform levels.

More than three quarters of respondents reported the publication of an Annual Report - see **Fig 13.4** Curiously, however, when analyzed by type of director, Chairs and Non-Executives were more likely to confirm such a publication than CEOs and Executives - see Table 13.4 - which has a Chi-squared value of 20.61654 and is highly significant at the 1% level. This may imply a difference between the

Fig 13.3
Frequency of DHA Public Meetings

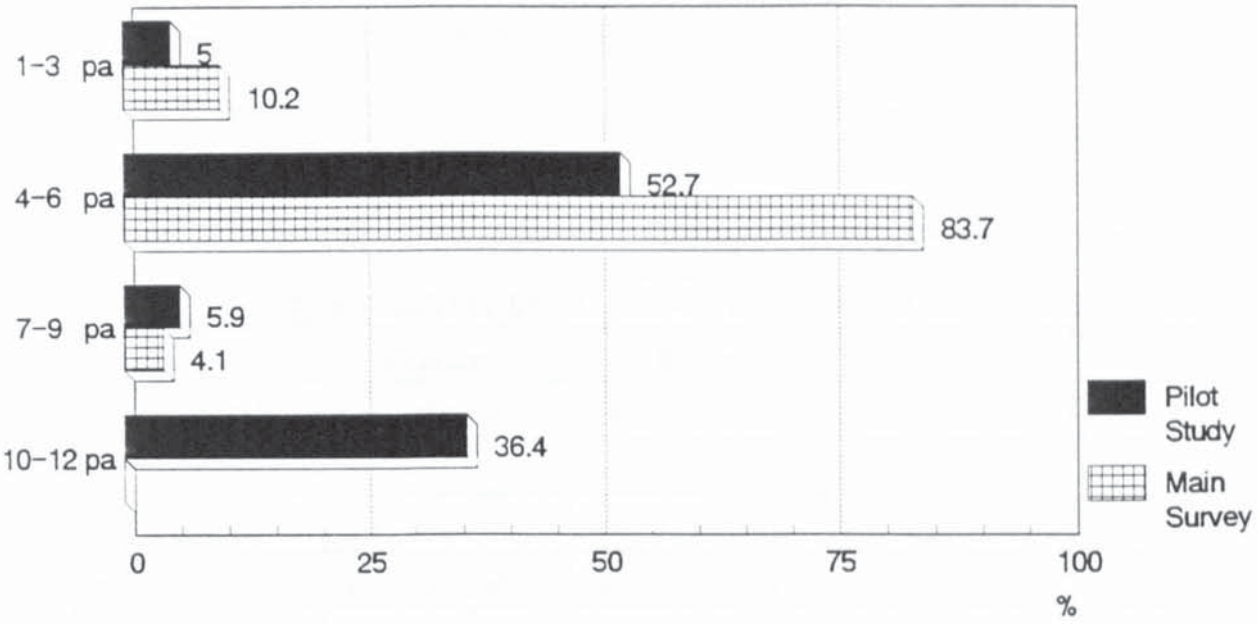
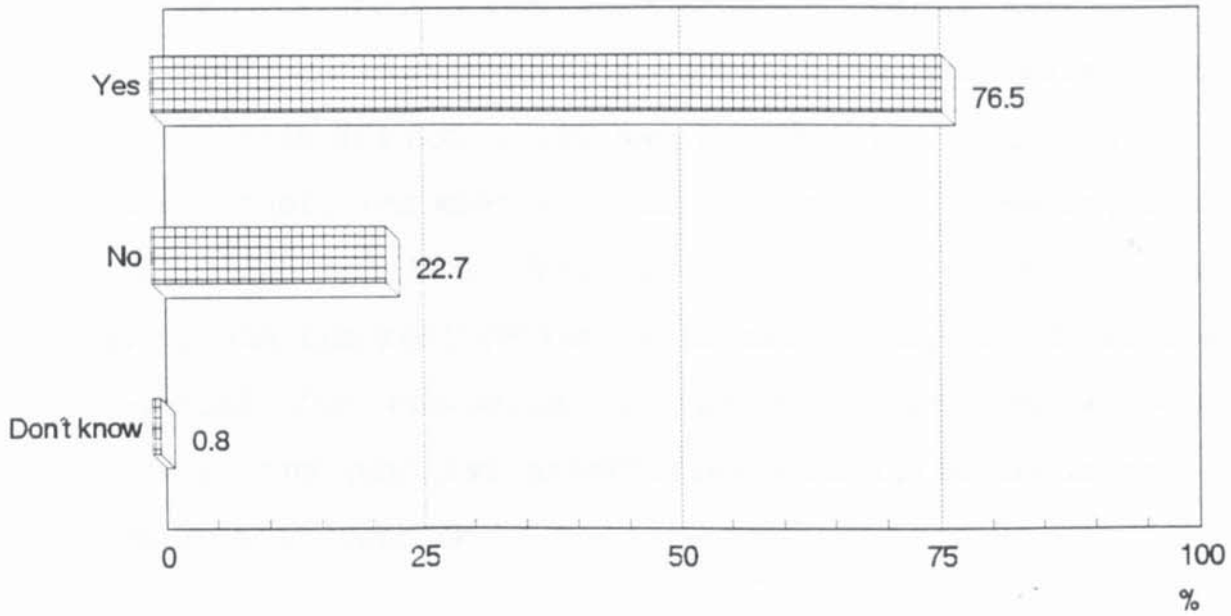


Fig 13.4
Publication of DHA Annual Reports



rhetoric and the reality, or, could it be an anomaly whereby Chairs and Non-Executive directors have confused the publication of the Director of Public Health's report each year with the Authority's Annual Report ?

Table 13.4
The Publication of Annual Reports by DHAs

	Chairs	NEDs	CEOs	Excts
n = 238	23 (100%)	108 (100%)	24 (100%)	84 (100%)
Yes	19 (82.6%)	95 (88.0%)	14 (58.3%)	54 (64.3%)
No	4 (17.4%)	12 (11.1%)	10 (41.7%)	29 (34.5%)
Don't know	0	1 (0.9%)	0	1 (1.2%)

The inclusion of accountability references in a mission statement, the existence of value statements, explicitly defined posture towards key stakeholders or an ethical code did not in any way increase the frequency with which Authorities meet in public. They did, however, seem to increase the likelihood of a statement concerning the public and the publication of an annual report. Given the potential for confusion in the minds of respondents, however, any positive association identified needs to be treated with caution.

13.3 Discussion

Any discussion of accountability must assume that:

* those who are to be held to account have themselves some *a priori* justification for undertaking that for which they have to account
* that they - and those who require their accountability - interact together, and,
* that the indirect or direct accountability process is conducted within implicitly understood or explicitly agreed parameters.

The discussion which follows will therefore take these critical themes - legitimacy, inter-group relations and the practical means of expressing accountability - to give shape to the debate.

Turning first to the notion of **legitimacy**, doubts have existed for some time as to the extent of popular support for, and therefore the validity of, appointments to District Health Authorities (and other health bodies). For much of their history Health Authorities conducted their business largely out of the public gaze. As health care became increasingly politicised and concern grew about corporate "sleaze" and standards of conduct in public life, interest has grown and the debate intensified.

Corporate governance perhaps broke the surface of general awareness with the publication of the Cadbury Report (Cadbury, 1992), itself a response to private sector malpractice. Such poor standards of organisational conduct

anged from the Maxwell case (Stiles & Taylor, 1993; Clarke, 1993), which was explicitly criminal, to the conduct of British Airways which was implicitly and ethically dubious (Monks & Minow, 1995 p376). Indeed as Cowen & Osborne (1993, p9) observe, "entrepreneurs frequently live in a world of ungoverned prerogative". This then was the backdrop against which subsequent and unwelcome developments in the public sector were to be viewed. The conduct of individual MPs and, in particular, the alleged appointment of Government supporters to quangos, provoked allegations of public sector "sleaze". The political pressure which ensued resulted in the establishment of the Committee on Standards in Public Life under the chairmanship of the Lord Nolan (Blitz, 1994). A little later, public concern about executive reward - particularly in the then recently privatised utilities - reinforced doubts concerning boardroom behaviour and decision making. Government almost immediately supported the establishment, by the City of London, of a Study Group on Directors' Remuneration under the chairmanship of Sir Richard Greenbury (Kuper & Lewis, 1995). Such were the conditions which gave rise to public disquiet and the growing strength of the left wing critique, both of which challenged the issue of legitimacy.

The left wing critique is less a single coherent view than a general position derived from separate strands. The first strand focuses upon "the accountability of the new

magistracy" (Stewart, 1992 p7). Although Stewart was expressing concern about Local Government his words are now seen to have a wider resonance:

> "In 1888 responsibility for the administration of counties was taken away from the magistrates, a lay appointed elite, and given to elected councils. A new magistracy is being created in the sense that a non-elected elite are assuming responsibility for a large part of local government."
>
> (ibid, p7)

Jack Straw, when shadow environment secretary, went further:

> "The unelected quango state is also the unaccountable and corruptible state..."
>
> (Davies, 1993 p14)

A second theme challenges the substitution of markets in place of hierarchy (e.g. Maidment & Thompson, 1993) and disputes the notions of both citizen as consumer and market choice as alternatives to 'true' accountability (e.g. Plumber, 1994).

> "While the reforms were being implemented, much less attention was given to how quangos should be accountable and to whom. Governance structures were created without clear and consistent principles or methods. Several years on, the results of this oversight are becoming apparent. There is deep public unease about the legitimacy of many quangos, both among the general public and amongst those working in them."
>
> (ibid, p1)

The concept of a "democratic deficit" (Hunter, 1995; Cooper *et.al.*, 1995) has accordingly grown - in part from the left wing critique and in some measure from an appetite for constitutional reform (Economist, 1995). The representation of interests in a democratic society are normally concerned with the representation of personal, class or sectional interests and/or by delegated representation (Birch, 1971 p72). If Health Authorities are taken to be examples of delegated representation the evidence from this study (see particularly Chapter 10) and from Cairncross *et.al.* (1991) suggests that the age, class, gender and ethnic mix of Health Authority boards do not reflect the diversity of the communities they serve. More recently the issue of Health Authority accountability has been given an added frisson with growing economic pressure and the advent of more explicit rationing:

> "Health authorities are now understood to have responsibility for complex ethical issues of political sensitivity but, as presently constituted, they have no mandate to make such ethical and politically contentious judgements."
>
> (Cooper *et.al.*, 1995)

The response to issues of legitimacy has been mixed. Government, via the Nolan Committee, has sought to improve standards in public life and, in particular, to make appointment procedures sound and transparent (Cm 2850-1, p68). The opposition Labour Party, although proposing changes in balance and emphasis, envisage the continuation

of Health Authorities and "welcomes the Nolan Committee recommendations for the appointment of health authorities and trust boards..." (Labour Party, 1995 p20). In both cases therefore the parties assume the continuation of Health Authorities, the only real difference lying in the means each would adopt to increase the perceived legitimacy of such bodies.

As noted above accountability is a dimension of a formal relationship between two or more parties; accountability therefore necessarily involves **relations with others**. In a private sector context, this implies the need for a responsible attitude towards a range of key stakeholders:

* customers
* employers
* suppliers
* investors, and towards,
* the broader community
* the political community, and
* the physical environment.

Such an approach can create a climate in which legitimacy is seen to exist, or at least is not challenged, e.g. The Body Shop, or, as a necessary pre-condition of mature and accountable relationships between those concerned. If, for example, we compare selected findings from Clutterbuck

et.al. (1992) and this study - see Table 13.5 - we see that the private sector has a more developed posture towards the community and its own staff, but, a more comparable position regarding suppliers.

Table 13.5
Comparison of Private Sector and NHS Policy 'Positions' in Respect Key Stakeholders

Stakeholders	Private Sector *	NHS **
Community	83%	55%
Employees	83%	49%
Suppliers	50%	41%

Source: * Clutterbuck *et.al.* (1992, p291)
** Doctoral Research

Given the role of District Health Authorities, i.e. to purchase health care for their local community from suppliers (NHS Trusts and others), such underdeveloped thinking in the case of both groups is disturbing. In terms of the former, the evidence tends to support the assertion that:

> "the government's *Local Voices* initiative to involve the public in commissioning, launched three years ago, has been confused, inconsistent and poorly co-ordinated"
>
> (Crail, 1995 p11)

In terms of their relationship with NHS Trusts it would appear that there is little dialogue with suppliers outside the formal negotiation and agreement of contracts.

It is important therefore that District Health Authorities fully appreciate the importance of organisational legitimacy (see e.g. Sutton, 1993), comprehensively map their stakeholders (IOD, 1995 p38) and conduct and act upon a social responsibility audit. Such audits (see e.g. Clutterbuck *et.al.*, 1992 p288) allow an organisation to develop a considered position in respect of each of its stakeholders and to systematically pursue focused relations. Although perhaps more relevant to the private sector, a growing interest in the environmental record of organisations - in terms of pollution, consumption of raw materials, land use etc. - may signal a growing ethical dimension in stakeholder relations. Will Health Authorities have to develop ethical purchasing policies ?

Finally, in terms of stakeholder relations, Health Authorities are seen by their directors as paying 'most' attention to their relations with the community. That said, at only 55% this is low in comparison with the private sector - see Table 13.5 above - and might be assumed to be due to the role, importance and dominance of the higher tiers of the NHS hierarchy. Such tiers can be thought of as acting in a manner analogous to 'the institutions' in the private sector. Their views, knowledge and power exceed those of the typical individual or community. To be internally consistent one might have expected a more clearly developed position in regard to "other NHS bodies"

- quite the reverse. This suggests, overall, a somewhat inward looking and isolationist position on the part of many Health Authorities - a distance which may be perceived as aloof and a level of interchange which may suggest reticence at best or secrecy at worst.

In concluding this discussion of accountability we need to turn our attention to **the practical means of expressing accountability**. For much of the NHS's history "the medical profession retained its position as the dominant structural interest" (Ham, 1986b p129); the "professional monopolists" (Ham, 1992 p223). This reflected both the political climate of the time and the functionalist views of Parsonian sociologists in that "the development of modern society was associated with the development of modern professions" (Alasyewski & Manthorpe, 1995 p41). This changed, however, in the face of 'the crisis of legitimacy' in the 1960's and the rise (and rise) of the "corporate rationalisers" (Ham, 1992 p223). The emergence of a powerful countervailing force in the form of a managerial elite was boosted considerably with the managerialist public sector reforms of the 1980s and 1990s (Pollitt, 1990; Hood, 1991).

The adoption of private sector models and practices has often raised simultaneous and conflicting views:

> "the dominance of calculability and rationalisation in private sector firms provide a powerful model of legitimacy which undermines abstract notions of 'service' or 'the public good'"
>
> (Morgan, 1990 p124)

In other words, the adoption and expression of private sector thought and practice can undermine confidence in a (post reform) system which was itself designed to rectify an earlier and discredited system of governance at District Health Authority level. Despite this:

> "people remain passionately committed to the NHS, but are less inclined than in the past to trust blindly in clinicians and to be grateful for what they get"
>
> (Crail, 1995 p11)

Such an overtly managerialist approach meant that the focus of accountability - an implicit trust in the professionals - was replaced by an explicit requirement to demonstrate performance; and to account for any shortfall. What followed in the NHS included the introduction of performance indicators, management reviews etc (see Chapter 2) and the investment of personal responsibility in a named General Manager (DHSS, 1983). Generally, the professions resisted such measures, retreated into an ideological redoubt and, in the case of Medicine, increasingly 'fell behind the pace' (Harrison, 1995). Thus in a relatively short period - between the mid 1980s and the mid 1990s - the focus of accountability in health care moved from the professions to the manager.

This was a relatively short lived episode for no sooner had the focus shifted and the assumptions changed then things began to go wrong. A number of spectacular scandals ensued (see Chapter 4) and Parliament - specifically Robert Sheldon MP and the Committee of Public Accounts - became increasingly involved (CPA, 1994)b. As Ham & Haywood (1993, p60) reminded us:

> "In formal terms, boards act as agents of the Secretary of State and are accountable for their performance to him or her"

a tenet reinforced with the accountable officer initiative (BN 5/95, 1995) which sought to combine managerial and Parliamentary accountability by making named managers - in part at least - directly accountable to Parliament. The constitutional position in the UK, is that accountability for the NHS is essentially and ultimately Parliamentary i.e. via the Secretary of State on the floor of the House of Commons. The allegations of 'sleaze' began to cast doubt on such a process and to undermine the moral authority of Parliament. At the time of writing the pendulum has begun to swing away from central accountability towards the increasingly attractive 'purity' of local accountability.

Local accountability - and its close companion local democracy - are ideas which have on their own or together been flirted with throughout the life of the NHS. Indeed David Knowles, the incoming president of the Institute of

Health Service Management, argued in 1993 the case for Local Government taking over the purchasing role of Health Authorities (NAHAT, 1993 p6). A view subsequently reinforced by Cooper *et.al.* (1995). Whilst local democracy is a compelling idea it is not one which has found favour with Government. Why should this be ? The case against Local Government control of the NHS stems from the following:

* it would undermine the concept of a National Health Service
* the purchase of services transcend the boundaries of a particular Local Authority
* the increasing number of Health Authority amalgamations
* the funding of the NHS is largely through general taxation and national insurance contributions
* professional and cultural barriers between social services and the NHS will not easily (if at all) be overcome by organisational change
* changing patterns of service delivery are likely to require a continued strategic overview at a regional level
* MPs are unlikely to relinquish their direct involvement
* the poor organisational and cultural reputation of Local Government
* GP Fund Holders - who are also purchasers - would remain outside the framework
* local democratisation would undermine the separation of purchasers and providers

(NAHAT, 1993 p11).

It would seem, therefore, that the NHS has little alternative but to be committed to a pattern of democratic accountability which is predominantly to and through

elected MPs, whilst simultaneously seeking public legitimacy and the popular support of people at a local level:

> "The accountability of a public authority is not guaranteed by periodic elections, but requires a continuing exchange or dialogue with the electorate in which the public can both obtain and provide information, while the authority is open to scrutiny, listens and responds. This process informs the authority's decision-making between elections as well as voters' choices at election time. Active, participatory democracy complements and validates representative democracy."
>
> (Cooper *et.al.*, 1995 pi)

Despite the fact that the membership of District Health Authority boards is predicated upon a *personal* contribution (CM 555, 1989)), almost from the outset Non-Executive directors have frequently been depicted in a somewhat different light:

> "One of the prime reasons for having non-executive directors on the board is to safeguard the public interest. Although they are not elected, they are seen as the representatives of the public."
>
> (Wall, 1993b p21)

Despite this the Code of Accountability was very clear about statutory accountability:

> "The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS authorities and trusts, who are thus accountable to the Secretary of State and to Parliament".
>
> (DOH, 1994 p7)

and set out reporting obligations in the following terms:

> "It is the board's duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily understood assessment of the authority's or trust's performance to:
>
> * the NHS Executive, on behalf of the Secretary of State
> * the Audit Commission and its appointed auditors, and,
> * *the local community*" [authors italics].
>
> (ibid, p11)

Indeed the subsequent publication of the Code of Practice on Openness in the NHS (NHSME, 1995) has done much to reinforce this and to ensure that a range of documents are published by District Health Authorities (ibid, p12):

* an annual report
* an annual report by the Director of Public Health
* papers, agendas and minutes of board papers
* annual audited accounts
* five year strategy
* annual purchasing plans
* contracts with providers
* a register of board members' private interests.

The Audit Commission went further arguing that NHS boards needed to be responsive to the community in terms of "informing the public, taking account of the public's views and answering to the public" (Audit Commission, 1995 p23).

In terms of 'taking account of public views' it supported District Health Authorities in consulting community groups undertaking public surveys or establishing focus groups and, importantly, that District Health Authorities "ensure that local opinion features when the board is formulating strategy" (ibid, p24). The Audit Commission was less emphatic in dealing with 'answering to the public'. They endorsed the idea of the board being questioned in public and advanced the concepts of a "citizen jury" (see also Millar, 1996) and "consumer laboratories". The former was later endorsed and "electronic democracy" added by Cooper *et.al.* (1995).

It remains to be seen the extent to which District Health Authorities embrace measures beyond the statutory minima in respect of their reporting obligations. For just as there are those who sincerely feel concern about the march of the unelected state, so to are there those who feel confident about the present accountability framework.

> "Far from there being a democratic deficit, the accountability of the NHS to Parliament imposes a complicated and sometimes bureaucratic system of checks and balances to ensure that the NHS is responsive to the wishes of democratically elected MPs."
>
> (NAHAT, 1993 p11)

- Chapter 14 -

The Postal Survey: Board and Director Development

14.1 Introduction

This chapter will report further findings from the postal survey concentrating on the sphere of board and director development.

14.2 Factors Influencing the Performance of Board Members.

Perhaps the most obvious factor in this area is the extent to which board members are formally inducted into their role. 61.4% of respondents to the survey reported the existence of a programme of induction, 31.5% said there was not and 7.1% did not know. Although this is an important overall deficit, further analysis reveals a striking imbalance in the experience of board members - see Table 14.1 From this it is very clear that the opportunities afforded Chairs and CEOs is in marked contrast to Non-Executive directors and Executives. This difference has a Chi-squared value of 9.5020876 and is highly significant at the 1% level.

Table 14.1 The Induction of Board Members in DHAs		
	Chairs & CEOs	NEDs & Excts.
n = 241	47 (100%)	194 (100%)
Yes	38 (80.9%)	110 (56.7%)
No	8 (17.0%)	68 (35.1%)
Don't Know	1 (2.1%)	16 (8.2%)

The absence of provision for a little more than a third of Non-Executive directors and Executives) is not merely the absence of a social opportunity, but goes to the very core of board members perceptions and understanding of their role.

When asked if board members had been given information concerning their statutory obligations and legal responsibilities 59.4% of respondents indicated this was the case, 23.4% that it was not and 17.2% did not know. This strongly suggests that more than a third of board members may be unclear about their powers and duties. Analysis by role reveals two further and important insights - see Table 14.2 Firstly, Chairs (unsurprisingly) are very clear about such matters and much more so than any other type of director. Secondly, somewhat less than half of Executives are clear in this regard. The former speaks of the nature and importance of such appointments, the

latter of 'officers' still in transition to a full board membership role and corporate responsibility. These differences have a Chi-squared value of 20.089253 and are again highly significant at the 1% level.

Table 14.2
Awareness of Statutory Obligations and Legal Responsibilities in the Boards of DHAs

	Chair	NEDs	CEOs	Excts
n = 239	23 (100%)	108 (100%)	24 (100%)	85 (100%)
Yes	20 (87.0%)	66 (61.1%)	15 (62.5%)	41 (48.2%)
No	2 (8.7%)	24 (22.2%)	9 (37.5%)	21 (24.7%)
Don't know	1 (4.3%)	18 (16.7%)	0	23 (27.1%)

The Executives most likely to report a limited understanding of such matters were Directors of Finance (although not to a statistically significant degree) - see Table 14.3.

Table 14.3
The Awareness of Statutory Obligations and Legal Responsibilities by Executive Directors

	Director of Finance	Director of Pub Hlth.	Director of Purch.	Other
n = 85	25 (100%)	32 (100%)	14 (100%)	14 (100%)
Yes	9 (36.0%)	17 (53.1%)	8 (57.1%)	7 (50.0%)
No	8 (32.0%)	10 (31.3%)	2 (14.3%)	1 (7.1%)
Don't know	8 (32.0%)	5 (15.6%)	4 (28.6%)	6 (42.9%)

If for many board members there is either limited induction or information, on whom - within the board - do they model their behaviour ? Who influences their development and performance ? The detail is shown in Table 14.4

Table 14.4
Interpersonal Influence Within DHA Boards

n = 233	Director Role			
	Chair	**NEDs**	**CEOs**	**Excts**
Source of Influence	22 (100%)	104 (100%)	23 (100%)	84 (100%)
Chair	2 (9.1%)	63 (60.6%)	19 (82.6%)	6 (7.1%)
NED	3 (13.6%)	11 (10.6%)	0	1 (1.2%)
CEO	16 (72.7%)	24 (23.1%)	0	73 (86.9%)
Exct.	1 (4.5%)	6 (5.8%)	4 (17.4%)	4 (4.8%)

Chairs and Executives see themselves as being predominantly influenced by their CEO; CEOs and Non-Executive directors by their Chair. This distinction has a Chi-squared value of 118.69938 and is highly significant at the 1% level. Development is therefore a much more subtle inter-personal process than an explicit one. To what extent this is desirable or effective remains an open question.

Aside from the benefits to directors of contact around the boardroom table, these data reveal that there is also some social contact. Indeed 91% of respondents reported that this took place either very frequently (46.6%) or

occasionally (53.4%). Deeper analysis - see Table 14.5 - suggests that this is more likely to be the experience of Chairs and CEOs than Non-Executive directors and Executives, which has a Chi-squared value of 5.5372072 and is significant at the 5% level. This may indicate the use of social contact as an important means of bonding the Chair/CEO axis.

Table 14.5
Social Contact Between DHA Board Members

	Chairs/CEOs	NEDs/Excts.
n = 221	45 (100%)	176 (100%)
Very frequently	28 (62.2%)	75 (42.6%)
Occasionally	17 (37.8%)	101 (75.4%)

Finally, respondents described relationships in the boardroom in very positive terms. 95.3% viewing them as either close or as cordial. Chairs & CEOs were somewhat more likely to describe relationships in terms of the former, NEDs and Executives in terms of the latter, but not to a significant degree. This level of harmony, while doubtless satisfying to those involved, may narrow the 'distance' that needs to exist between Executives and Non-Executives to enable the latter to exercise independent scrutiny. This may be an inadvertent consequence of much 'team building' or a more subtle process of 'capture' on the part of Executives.

14.3 Discussion

Perhaps the single most critical finding in the realms of board and director development is that somewhat less than two thirds of respondents reported being provided with information concerning their **statutory obligations and legal responsibilities**. This is important since it may suggest that 1:3 respondents overall - but particularly Non-Executive directors and especially Executives - may be unclear about their powers and duties. Does this matter ? Of course it does, specifically in terms of initial decision making and subsequent performance. In its publication *A Practical Guide for Non Executive Directors,* Pro NED[1] (undated) recommends that prospective Non-Executive directors satisfy themselves on a number issues - including a clear understanding of the board and its functions and of the role of a director - prior to accepting a Non-Executive directorship. This latter point is acknowledged in the extensive and detailed information provided to private sector directors by the Institute of Directors (IOD) on "a director's legal status, powers and duties" (IOD, 1991 p116). The findings from this study suggest that Non-Executive directors accept and then function, in some cases, with only a partial understanding of such matters. Indeed doubts are now beginning to appear

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[1] Pro NED is a private sector pressure group which is run as a limited company on behalf of its sponsors - e.g. The Bank of England, The London Stock Exchange - to advance the interests and development of Non-Executive directs (NEDs). The organisation speaks on matters of Corporate Governance and, importantly, maintains a database of suitable Non-Executive director candidates.

concerning Non-Executive directors' understanding of their legal powers and statutory responsibilities on Trust boards (Long & Salter, 1994) and on the boards of NHS bodies per.se. (Brophy, 1995). Such concerns raise, respectively, important questions about directors understanding of the particular - corporate status, powers and independence - and a more general appreciation and acknowledgement of matters of liability. The case of Abigail Kirby-Harris, the former Trust chair who claims that her fellow directors libelled her in a letter of no-confidence, is a case in point (Parker, 1995). It appeared to come as something of a surprise to the Non-Executive directors concerned that the laws of libel could be invoked, and, that in such circumstances, they were not exempt by virtue of their directorship or indemnified by the Department of Health. The case[2] reveals a somewhat simplistic, even naive, appreciation of a particular facet of a Non-Executive director's statutory obligations and legal responsibilities.

An association between **director performance and corporate effectiveness** has long been recognised (Heskett *et.al.*, 1990; Pettigrew & Whipp, 1991; McKiernan 1992) and, at the highest level, has resulted in much exhortation

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[2] The case was settled in February 1996 following an apology and the withdrawal by the defendants of their original statement. The precise terms of the settlement were described as "confidential" and it is believed that the £250,000 costs was paid by the NHS Executive.

(e.g. Cadbury, 1992 p24):

> "The weight and responsibility carried by all directors and the increasing commitment which their duties require emphasise the importance of the way in which they prepare themselves for their posts. Given the varying backgrounds, qualifications and experience of directors, it is highly desirable that they should all undertake some form of internal or external training; this is particularly important for directors, whether executive or non executive, with no previous board experience. Newly-appointed board members are also entitled to expect a proper process of induction into the company's affairs. It is then up to individual directors to keep abreast of their legislative and broader responsibilities."

The Institute of Directors go further and identify three "key areas of director knowledge and understanding":

Specific to Boards

- corporate governance
- board roles, relationships and processes
- board standards of good practice
- corporate finance and accounting principles and practices

Specific to the Company

- evaluating strategic options and risks
- strengths and weaknesses of the company
- selection, appraisal, remuneration and development of directors
- company memorandum of incorporation and articles of association

Relating to the Business Environment

- contemporary thinking and developments
- public affairs and corporate communications
- political, economic, social/cultural and technological influences
- key trends in the company's environment

(IOD, 1995 p52)

These represent both broad principles and particular areas of knowledge that the NHS could most usefully emulate. More specifically board and director development can be thought of in terms of individual interventions: either in terms of induction and/or on-going development programmes. Alternatively they can be conceived of as collective interventions: as a simple one off team building event, a regular programme of single away days or as a systematic and deliberate programme of shared learning.

Individual approaches to development most often centre upon induction which, the findings from this study suggest, are uneven in the NHS. Not all directors have equal access and there is also some slight geographical variation. Recognising induction is frequently "poorly structured and haphazard in its presentation" (Fitzgerald, 1993), Fitzgerald *et.al.* (1993) proposed a six tier approach with individuals starting at the tier which matched their particular needs:

* Tier 1: Basic information on the NHS as a whole
* Tier 2: Data on the context of the boards operations
* Tier 3: Understanding functional data
* Tier 4: Information on the organisation itself and its priorities
* Tier 5: Key personalities, roles and relationships
* Tier 6: Data on the current key issues facing the organisation

(ibid, p4)

This is a laudable approach which one would endorse and which is consistent with the Institute of Director's areas of knowledge.

Collective approaches to development are, however, rather more common and may be thought of as either implicit or explicit. Implicit development centres around the process of director socialization in which directors in some measure model their thinking and behaviour on that of their peers (Spencer, 1983). Important in this respect is the informal contact between directors and particularly between Chairs and their CEOs, which takes place outside the boardroom. An extension of this is also to be observed in the networking behaviour of directors which, previously unstructured, is becoming increasingly formalised, e.g. as learning sets, in which groups of directors (from different boards) share information and/or learning in a safe environment. Necessarily, therefore, most collective approaches to development are explicit; the nature of interventions being themselves shaped by notions of individual competence or corporate performance.

The notion of individual **competence** in respect of directors is informed firstly by distinguishing between:

* competence: which is concerned with the performance of work in an effective and efficient manner

* competency: which is a dimension of management ability and behaviour required for competent performance to take place

(Pierce, 1994 p150)

centring upon a tentative set of director skills:

* a reflective orientation
* an external focus
* a long-term time horizon, and,
* a holistic view to decision taking

(ibid, p151).

Such a debate is, necessarily, also concerned with the related, but much less positive, concept of incompetence. Although less precisely defined, Ott & Shafritz (1994) suggest that incompetence is:

* a state of unworthiness
* a term which is neither neutral or value free
* varies in degree and pervasiveness
* involves patterns of seemingly avoidable bad decisions or unwise actions
* persists over time and may become rooted in an organisation's culture

(ibid, p372)

but go on to suggest that they are "uncertain that organisation competence and incompetence are polar opposites" (ibid, p372), implying that competence represents little more than adequacy. Although the

competence/incompetence dimension can cover both the individual and the organisation, it is perhaps most often associated with the individual and the strategies and interventions pursued reflect this i.e. induction and periodic and/or on-going programmes of individual development.

The concept of **performance** is also an important part of the debate about individual and corporate effectiveness. Wall (1993a, p5) suggests that important dimensions of performance for NHS bodies concern:

* NHS boards are responsible for policies, process, performance and probity
* NHS boards are accountable for effective use of resources
* NHS boards must observe the law
* NHS boards must have a chairman, a chief executive, non-executive directors and executive directors
* NHS boards have responsibilities to the public; users; staff.

Taking this further Demb & Neubauer (1992, p172) suggest the criteria for assessing board performance should concern - the directors themselves; in terms of the role, doing the right thing; in terms of working style, doing things right - central to which is the need to evaluate progress via regular audit (ibid, p183). Sheridan & Kendall (1992) reinforce the general proposition - that excellence in governance resides in boardroom effectiveness - but propose

a more detailed and systematic boardroom audit (ibid, p209) - see **Fig 14.1** Like the competence debate, although effectiveness encompasses both individual and organisational dimensions, it is often associated with the latter; in particular with team building activities and programmes of collective development which involve several or all members of a particular board.

A criticism of the approaches discussed thus far is that they tend to be uni-dimensional i.e. concerned with competence, with effectiveness or simply with particular forms of intervention. More recently an 'inclusive' approach has grown in stature and importance. Although most of the recent contributors to the literature advocate a more comprehensive analysis (see e.g. Coulson-Thomas 1993a; 1993b) the major innovation lies in the response to such an exercise with Garratt (1990), Pedler et. al. (1991) and Neubauer (1994) advocating "learning organisation" strategies which involve systematic, continuous and collective learning and adaptation.

> "The Learning Company is a vision of what might be possible. It is not brought about simply by training individuals; it can only happen as a result of *learning* at *the whole organisation level*:
>
> > A Learning Company is an organisation that facilitates the learning of all its members *and* continuously transforms itself.

Fig 14.1
The Boardroom Review Programmee

Source: Sheridan & Kendal (1992, p211)

> This is the dream - that we can design and create organisations which are capable of adapting, changing, developing and transforming themselves in response to the needs, wishes and aspirations of people inside and outside."
>
> (Pedler *et.al.*, 1991 p1)

Garratt (1993, p24) has proposed an 'alternative' model of corporate governance consisting of four fields - policy formulation, strategic thinking, supervising management and accountability - and advocates a systematic and cyclical review process within the board that yields collective insight, joint action and thus shared learning, growth and change. He does, however, ironically observe that "directing is the only professional calling where one practices first and trains later - if you are lucky or wise" (ibid, p23).

The growth in interest in corporate governance has been matched by a corresponding desire to respond to the opportunities that board and director development present. In the private sector, the Institute of Directors has published reports setting out development needs (e.g. IOD, 1990) and has been the focus of advice and training over a number of years. The Institute established in 1992 the Centre for Director Development (Harper, 1992). An almost identical pattern can be seen in the NHS. The National Association of Health Authorities and Trusts has acted in a manner analogous to the Institute of Directors for the boards of NHS bodies and, in like manner, has been the

focus of internal and sponsored research, advice and training. NAHAT established a Centre for Board Development in 1995.

The Centre for Board Development provides a variety of modular training programmes consisting of four "core" modules:

* an introduction to the NHS
* the NHS board
* NHS funding and finance
* monitoring performance

and seven optional modules:

* priority setting
* business planning
* communications and the NHS
* mental health services
* people and pay
* understanding general practice, and,
* handling appeals and complaints.

Participants can combine all of the core modules with two of the options to "graduate" with a Centre for Board Development certificate - at an individual, non-member price of circa £1520.00.

The National Association of Health Authorities and Trusts came into being on 1 August 1990, formed from a

merger of the National Association of Health Authorities and the Society of Family Practitioners. It is a representative body for family health service authorities and health authorities; also for NHS Trusts and GP Fundholders. Its primary role is to express the collective views of its membership on important national issues affecting the NHS. In developing and furthering such interests NAHAT aims:

* to foster co-operation and communication between the NHS authorities, government departments, local authorities and other organisations concerned with health matters;
* to educate and inform the public about the achievements and needs of the NHS;
* to promote research, education and the exchange of information within the NHS;
* to advise government and professional bodies on issues relating to the NHS;
* to investigate specific problems of concern to its membership.

(Wall, 1993)

While such a body has provided an essential focus for debate and development and advice via, for example, its range of publications and activities:

> "The extent to which induction training is undertaken varies greatly between quangos. The NHS has a reasonably good record, partly reflecting the work of the National Association of Health Authorities and Trusts (NAHAT) which has established a Centre for NHS Board Development."
>
> (Cm 2850-1, 1995 p94)

it has also developed some of the less pre-possessing qualities of a pressure group. Most particularly it has been colonised by a small number of academics (and activists) who provide analysis, and advice (and motive power), but on a comparatively narrow waveband. Such ideological and intellectual imperialism has done much to reduce the quality of debate and constrain the development of boardroom practice.

Understandably perhaps, the bias in much of the literature is to favour the development needs of Non-Executive directors or of boards as a whole. As a consequence **the development of executives** has been somewhat overlooked or eclipsed. In the past, when managers managed and were in any event subordinate to the members of District Health Authorities, their development needs were seen to be both separate and a responsibility of the individual/the Service. Today the requirement for sound management is no less important but, in addition, the executive has also to discharge its corporate responsibilities. Indeed Stern *et.al.* (1995, p2) have observed that executives "still spend most of their time managing rather than directing" and, as a consequence, "still tend to see themselves as senior managers rather than directors" (ibid, p13). It follows that some effort needs to be made to ensure that Executives are adequately developed for their new role and responsibilities. Broadly,

the same sort of options are open to the Executive director as are open to other board members:

* isolated events or continuous development
* individual or collective interventions
* springing from notions of or judgements concerning competence or performance.

Although needs clearly vary, Executives have tended to favour mentoring, learning sets, cross sectoral secondment or the acquisition of an MBA (or even a DBA) as valid options.

This chapter has considered the findings from the survey concerning the performance and development of directors and has discussed in some detail their significance. In particular notions of individual and collective performance were explored and the case for the isolated or continuous development of individuals or groups judged. In a broader sense Chapter 14 has completed the reporting of the survey findings. But, to what extent can we be confident that the reported views and behaviour of directors is actually what they think and do ? It is to a consideration of this that we now turn and in particular to the picture to emerge from the case study Authorities.

- Chapter 15 -

Case Study Alpha

15.1 Preface to the Reporting of the Case Studies

This chapter sets out the findings from the first of the three case studies undertaken as a part of this research. Although methodology (see Chapter 7) and methods (see Chapter 8) have been fully discussed, it is important to recall that the case studies were undertaken to achieve a measure of triangulation (Denzin, 1978a; 1978b) - methodological triangulation (postal survey and case study) and data triangulation (questionnaire, interview, observational and documentary data) - over time, location and context. In addition, the case studies offered an opportunity to explore the "ecological fallacy" (Robinson, 1950), i.e. to compare and contrast the attitudes and opinions of directors as reflected in the postal survey with actual behaviour in and around the boardroom.

Three case studies were chosen on the basis that two were believed to be necessary (Sudman, 1976) but, with 50% inbuilt redundancy should access to any Authority have been refused or foreclosed. In the event this did not take place and, accordingly, all three cases will be reported. The approach taken will be to report each case study separately

- with only the occasional cross reference - which will be followed by a formal cross case analysis (Yin, 1991 p134).

The specific Authorities were chosen from the largest NHS region in England and reflect a range of contexts - rural, urban and metropolitan - each of which was visited twice with an intervening gap of several months. The first visit involved interviewing the Chair, a Non-Executive Director, the CEO and an Executive together with observing a public and non public meeting of the board. The second visit involved interviewing only the Chair and the CEO and attending one meeting of the board. Over the three case studies this involved some 30hrs of interviewing and some 24hrs observing boardroom activity. In all cases entry was successfully negotiated directly with the Authority Chair who, thereafter and without exception, was open and supportive. I acknowledge without reservation their help and frankness.

15.2 The Nature and Context of Alpha Health Authority.

Alpha is a Health Authority headquartered in a medium sized county town but purchasing health care for a population of 269,000 spread throughout a large geographical area (390 square miles). The population served is mostly to be found in one of three towns, in a number of smaller concentrations and throughout a diffuse rural

community. The present configuration is the result of the merger of the purchasing components of two, previously neighbouring, District Health Authorities in October 1992. The purchasing allocation is some £97.6m of which £1.6m is spent on commissioning. The Authority employs a staff of 43.

Although the NHS & Community Care Act 1990 provides for a DHA board comprising a Non-Executive Chair, five Non-Executive Directors and up to five Executives (which must include the CEO and Director of Finance), at the time of the initial visit (in the summer 1994) there was one Executive and two Non-Executive director vacancies. It did not appear to be the wish of the Authority to appoint a fifth Executive and, the effects of an existing Non-Executive vacancy, had been exacerbated by the recent and unexpected death of a Non-Executive director. The board therefore consisted of a Chairman (a retired farmer and former District Councillor), three Non-Executives (a solicitor, a NED of a prominent local manufacturer and a voluntary services/former health care professional) and four Executives (the CEO, Director of Finance, Director of Public Health and a Director of Planning). The membership of the board reflected local history with some members, particularly the Non-Executives, coming in near equal measure from each of the predecessor Authorities. Of the eight strong board, four were women (two Executives and two Non-Executives); all were white.

The board generally, but specifically the Chair and the CEO, appreciated the growing importance of corporate governance. This stemmed from the NHS scandals (see Chapter 4)[1] and the consequent publication of the NHS Codes of Conduct and Accountability, three months prior to the initial case visit. There was also a genuine desire to respond to growing expectations and to operate effectively as a board.

15.3 Director Interviews: The Initial Case Visit

The director interviews were semi-structured and used an interview schedule which reflected the logic of Tricker's model of corporate governance (1984; also Hilmer & Tricker, 1990) and the areas explored in the postal survey - see Appendix 3. This was the framework which guided the exploration of local thinking and the practice of corporate governance in the *given* setting.

15.3.1 Direction The Authority appeared to be very clear about its purchasing responsibilities but perhaps less certain of its role as a board. One director felt the Non-Executive role was rather vague and that they were perhaps overly concerned with holding executives to account (Exct).

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[1] The Chairman and CEO of Alpha Authority had both been members the West Midlands Supplies Council subsequently investigated by the Carver Committee looking into the irregularities at the West Midlands Regional Health Authority.

That said, Alpha had established a clear corporate aim and seven "key principles" which, although not universal organisational values in the strictest sense, were used to shape strategy and test purchasing choices - see **Fig 15.1.**

Two views of what the key strategic issues were emerged during the initial interviews - one was concerned with securing an income and expenditure balance and one with establishing locality purchasing throughout the Authority's geographical area.

Fig 15.1
The Key Principles of Alpha Health Authority

* To achieve the correct balance of health care provision;
* To ensure the right balance between local and external providers;
* To achieve a high quality of health provision clearly specified and closely monitored;
* To obtain value for money in health care purchasing;
* To develop effective communication and working arrangements with public agencies, health care providers and the public;
* To secure sound information, and,
* To create opportunities for development.

Source: Annual Report Alpha Health Authority 1993/94

This may indicate either something less than unanimity, or, simply the complexity of the NHS and some tension between central and local priorities. In terms of member involvement this tended to be confined to the boardroom - "almost rubber stamping" (NED) - with few other opportunities and no audit or remuneration committees: "I'm not a committee man" (Chair).

15.3.2 Executive Management In general terms there was clarity about and a distinction between the role of the Chair and that of the CEO. They worked together well and closely, with the Chair spending 1.5-2 days per week on Authority business. Although there was an implicit understanding of the respective roles there was a recognition that what existed was a "negotiated order" (CEO), with the Chair leading in specific arenas i.e. embodying the Authority in public, at the political interface, and, in some measure, in inter-organisational relations. Other members of the board shared this view and clearly valued the balance and distinction between the roles hinting, obliquely, that the Chair had perhaps become rather less 'non-executive' in the period immediately prior to the appointment of the present CEO.

Although the board agenda was drafted by the executive and agreed by the Chair, Non-Executives were free to add items - but rarely did so. Decision making was seen to be fairly organic: "by consensus, only voting if in doubt" (Chair); "decisions tended to emerge" (CEO) but sometimes the recommendations proposed by the executive produced "some surprises" (Exct). Although Non-Executive opinion tended to suggest that the Executives were more equal than others, all were agreed it was the *board* that made decisions.

Without exception Non-Executives were seen as generalists "... full to the brim with common sense... to ask why, and never to be satisfied" (Chair). Indeed some Non-Executive Directors had developed a particular interest in finance matters and in the regulation of Nursing Homes but Non-Executives per se were not encouraged to become "Non-Executive experts" (Chair) and, in addition, the CEO was "not keen on shadowing". Executives were seen to be "adapting very well" to their new corporate role (Chair), having "left behind" the former officer/member relationship (CEO). That said, progress was seen to be good "on the whole" (NED), suggesting that there was indeed still some way to go. Indeed, all agreed that a particular executive director tended to operate only within the strict boundaries of that individual's discipline, was not a noted "team player" (Exct), had poor inter-personal skills (NED) and tended to have "odd brushes with members" (Chair) as a consequence.

15.3.3 Supervision Alpha had given consideration to the role of a 'Company Secretary' but rejected the idea. This seemed to be because it might "damage" the relationship between the CEO and the Chair/Non-Executive directors (CEO) and because it would have "added to management costs" (Chair). At the time of the initial visit there was little or no committee infrastructure. Although the Chair's view about such matters clearly prevailed, this was supported in terms of "we should not be having committees... it will

only add to the workload and the detail" (NED), yet challenged on the basis that committee activity would improve "trust and member involvement" (Exct)!

The quality of information necessary to facilitate monitoring and strategic control had some way to go but "we are getting to that... " (Chair). A more optimistic view was that "we are getting better" (CEO) and with an executive information system in prospect - for which "we have high hopes" (Exct) - the potential to provide detailed and "realistic" information concerning "waiting lists, contracts and outcomes" (NED). Perhaps because information was so rudimentary, the measures the board pursued to satisfy itself that its previous decisions had been implemented centred upon the formal minutes of their proceedings and associated action sheets. Whilst there is no suggestion that implementation was anything less than complete - indeed the executives reviewed progress with the CEO on a monthly basis - *board* action "non-executives are encouraged to test progress" (Chair) was unsystematic and incomplete and at least one director was "worried about this" (NED). In terms of individual directors, the performance of Non-Executives was dealt with "in part" (CEO) via "an informal talk" (Chair), a view which was not confirmed in the experience of the Non-Executive interviewed. Executive performance was managed via the "stick and carrot" Individual Performance Review system (Chair), although it was anticipated that this process

would widen if a remuneration committee was established.

Alpha had no explicit ethical framework it embraced, other than its statement of principles and there were no significant conflicts of interest. The Chair did, however, emphasise the need for directors to exemplify "high personal standards" and, in a public sector context particularly, to be "whiter than white".

15.3.4 Accountability Alpha did have a mission statement and seven "key principles". These did not, however, explain either to whom, or how, the Authority was accountable, although one of those interviewed was firmly of the view that this was "to the local population" (Exct). With the exception of service contracts and the human resource policy framework, which sought to merge the headquarters' of the two predecessor Health Authorities, there were no explicit and shared statements governing the relationship of the Authority with its key stakeholders.

The Authority met monthly and in public except for the months of August and December and although such meetings were open to the public - aside from staff, interest groups and the media - they were not well attended. In addition, there were regular non-public "member seminars" which were confined to the board and selected senior managers and tended to focus upon particular topics or problems. Alpha

published an annual report by the Director of Public Health (a statutory obligation) and a community newspaper, but not a conventional Annual Report.

15.3.5 Key Influences When directors were asked if they understood their statutory obligations and legal responsibilities a varied picture emerged. The Chair clearly understood his position since this had been made abundantly clear on appointment. By contrast the Non-Executives were believed to be uncertain about their obligations and responsibilities (executive) - a view the Non-Executive interviewee did <u>not</u> share. In terms of induction this was perceived to be "little or none" (CEO), or "patchy" (Exct) although information concerning director and board development was thought to transmit itself to directors "by osmosis" (Chair); they were also believed to derive much useful information from the National Association of Health Authorities and Trust's publications.

In terms of sources of internal influence, the views and experience of directors varied. The Chair tended to look to the executive "in the widest sense" but also his Non-Executives - both publicly/collectively and privately/individually; the Non-Executive directors to the executive and the Executives to the CEO. There was little in the way of social contact between board members outwith formal board meetings and seminars. Exceptions to this were retirement functions and "the Chairman's Christmas Quiz"

(Chair) or lunching individual Non-Executives on a personal basis (Exct). Interviewees seemed to suggest that social contact was unnecessary and an inappropriate use of public resources. Relationships were, however, described as "respectful and coming together" (Chair) and "stable" and "a little closer" (Exct). which seemed to suggest that whilst relationships were cordial there was significant underlying tension.

15.4 Director Interviews: The Second Visit

The second visit interviews involved only the Chair and CEO in each case study site and the brief account which follows adopts an 'exception reporting' convention, picking up only important differences and developments, or the lack of them. In the case of Alpha (visited in January 1995) there was a growing sense of resignation that the Authority - still completing the merger with its neighbour - was now required to combine with the Family Health Service Authority (and perhaps other Health Authorities ?) as a consequence of further reform and consolidation (DoH, 1993). In this particular instance the picture was further complicated by the Local Government Review which it was thought could have a material effect upon the organisation's ultimate configuration - "its like looking into a murky crystal ball" (Chair). There was also some pessimism that the county town, which was the centre of an existing and nearby Health Authority, would continue to

grow in importance and either eclipse or subsume Alpha. Although those interviewed clearly understood there was much still to be done in the interregnum, there was a sense in which "the Authority [was] on its death bed" (Chair).

Major changes in Alpha's operating environment reflected its uncertain present and future. Strategically there was a need to address growing financial pressures, largely stemming from Extra Contractual Referral commitments: "we will 'cash manage' these this year" (CEO), and, a need to address the reconfiguration of Acute Services. More immediately the board was faced with considerable personal uncertainty and declining morale amongst headquarters staff. In terms of board membership one Non-Executive had resigned due to family illness, one had been appointed (a management consultant), two Non-Executive vacancies therefore remained. One of the Non-Executive vacancies was held at the behest of the RHA given the upcoming merger with the Family Health Service Authority. The original Executive vacancy also remained.

In terms of overall direction, attention was shifting increasingly towards Provider performance - in particular a GP purchasing project (some 24% of budget), tighter contract management and also *Health of the Nation* (Cm 1523, 1992) targets. The Executive's corporate role had begun to "cut in" (Chair) and was now beginning to "mature" (CEO). Information in support of monitoring, however, still held

out promise but had not yet been realised as was the case with implementation monitoring. Alpha had published an Annual Report which contained information concerning directors' remuneration and interests. At the time of the second visit there was still no Audit or Remuneration committee.

15.5 The Directors of Alpha Observed

The board of Alpha were observed in operation on four separate occasions: at a meeting of the Authority in public on two occasions, at a non public "member seminar" and attending and hosting a public meeting.

In terms of the meetings of the Authority in public one was observed on the occasion of each case visit. Each meeting had clearly been publicised, was held in different and rotating locations and was easily accessible in well known public venues. The seating arrangements were semi formal with the Chair (with the CEO at his side) at the top of a U-shaped table arrangement; seating for the press and public being ranged across, but a little distance from, the open end of the U. Sat around the table was the board with Executives and Non-Executives mixed together, and, furthest from the Chair but still at the table, a range of invited guests, observers and Community Health Council representatives etc. The press and public normally numbered 2-4 in total.

On both occasions a conventional agenda was pursued - apologies, minutes, matters arising, chairman's communications, prime items of business and circulars - followed by a private part of the meeting from which the press and public were excluded. The principal variable was the number of business items which, as it happens, proved to be six on each occasion. Of the twelve prime items of business - one was a Public Health presentation, two were withdrawn/deferred, three were for decision and the remaining six were reports which were received/noted. Although the business conducted was both complex and wide ranging it centred upon a number of themes:

* investment in the development of the Authority's purchasing infrastructure
* monitoring purchasing i.e. activity, waiting lists and service quality
* monitoring resource use
* considering needs analysis and policy choice, and,
* discharging statutory functions.

The debate was inclined to be rather more animated in terms of the first three of the above five and rather less so in respect of the remainder. There was also some difference of view between Executives and Non-Executives, with the former seeking to invest in the development of Public Health capacity, whilst the latter sought to contain management costs. Although finance was a shared concern, there were differences of emphasis between Executives and Non-

Executives, with high(er) expectations on the part of the latter in terms of financial performance and reporting.

Both meetings looked and felt like formal meetings of a public Authority (rather than the business meetings of a board) yet were conducted in an open style. On both occasions the meeting paused at the mid point for tea and on two separate occasions, in each meeting, the public were given the opportunity to comment or ask questions; assorted guests also tended to contribute freely to the board's deliberations. On one occasion when the Authority resolved into private session, one member of the public left the room and seventeen remained around the table: eight directors and nine others ! Unsurprisingly, perhaps, there was no obvious change of mood, business simply carried on. Each of the meetings lasted rather more than two hours.

In almost complete contrast the remaining two occasions when the board was observed could not have been more different, from the monthly meetings in public described above, and from one another. The first was a six hour member seminar which ranged over three topic areas - the Authority's management arrangements, its management costs and the annual accounts. One had much more of a sense of a board at work, but with more open debate, greater participation and informally chaired. Ironically, although more obviously corporate - itself reinforced by a combative stance towards recalcitrant Providers - underlying tensions

between Executives and Non-Executives was evident (re Public Health staffing and financial performance and reporting).

The second 'non standard' meeting was in fact an extension of a conventional monthly meeting but was exceptional in both form and content. The meeting in question was concerned with the reconfiguration of Maternity Services in the town in which Alpha was itself located. A paper setting out the background, the options and a favoured choice was put to the preceding Authority meeting. In the evening, however, immediately following *that* meeting, the paper was presented to several hundred members of the public, their questions invited and observations heard - by the full board - who later withdrew, made a decision upon the matter and returned to announce the outcome to those present. Leaving aside the merits of the specific case the meeting was quite remarkable in the sense that:

* it was conducted in the face of evident public concern
* required the board to jointly present, explain and justify their thinking
* handle a large and passionate group of mainly women
* be seen to listen to and be influenced by what was said by the public
* be seen to take and then announce their decision upon the matter, and,
* all in the presence of the media.

In such circumstances not all members of the board could be seen to play an equal part. Notable roles and performances were those of the Chair visibly leading the board, explaining the Authority's position and accounting to the public; the CEO who had to finesse matters of detail and process; and the Director of Public Health who played the 'expert' role in terms of the proposed change and promoting the alternative pattern of provision.

The directors of Alpha were experienced, sincere and committed people who in different ways over a range of settings - from a typical public meeting of the Authority or the focused debate of a seminar to the emotion and tension of meeting with and accounting to the public - sought to discharge their responsibilities to the Authority and to the community.

15.6 Reflections on the Board of Alpha

In common with the boards of other NHS bodies, Alpha demonstrated areas of both considerable strength and some weakness. In terms of their **strengths**, much effort was made to conduct their regular business in public, for the general public to be made aware of this and encouraged to attend, and, in such circumstances, their further involvement encouraged and facilitated. In these terms their measures - to advertise their meetings, for the meetings to be held in rotating yet easily accessible

venues and for each public agenda to contain *two* opportunities for the public to raise questions - represents a standard that the boards of all NHS bodies should seek to emulate. This was not merely ritual good practice, for in one board meeting the formal letter to the Health Authority following its review by the RHA was debated in public and copies made available (often an Authority's review letter is considered on the private part of the agenda). In addition, the interaction between the board and the community, in the context of a public meeting concerned with Maternity Service, was an exemplar of "participatory democracy" (Cooper *et.al.*, 1995).

The **weaknesses** identified here largely represent unexploited opportunities rather than a failure to achieve an acceptable level of performance and can be thought of in terms of process, task and external relations. In terms of process, there is some lack of clarity concerning director roles - both to the incumbent of such roles and in the views Executives hold of Non-Executives and vice versa - and, in both cases, having a clear understanding of their statutory obligations and legal responsibilities. This lack of clarity appears to fuel some of the underlying tensions between directors. If this could be addressed by investing in board development, one might expect greater clarity, less conflict and improved cohesiveness. In terms of the latter, some modest changes to the seating plan at regular meetings would help to reinforce the identity of the board

and a clearer distinction between it, regular guests, and, the press and public.

In regard to the task domain the one area of some concern was the lack of a systematic and explicit process by which the *board* satisfied itself that the decisions it had taken had been implemented and, where appropriate, in a manner and to the time table agreed. A failure to demonstrate this seriously undermines a board's capacity to exercise its supervisory responsibilities - the issue at the heart of <u>all</u> of the NHS governance scandals. Clearly the quality and quantity of information in support of such processes is critical, an issue the board of Alpha appreciates and was committed to improve.

In terms of external relations, it was striking that the Authority had no explicit position statement concerning its stance on and attitude towards key stake holders e.g. the public, providers, its own employees and other NHS bodies. This is not to suggest that these matters had gone totally unconsidered, for they were reflected in various documents, in the attitudes of individual directors and, implicitly, in some of the strategies the board pursued. However, there was no coherent, explicit, shared and systematically pursued course which thus diminished in some measure the pattern of governance pursued in Alpha.

Finally, the context in which Alpha operated was not without challenge which pressed upon the board and thus upon the exercise of corporate governance. A particular concern was with provider performance and in particular with the reconfiguration of Acute Services. These issues were themselves influenced by and in turn produced consequential financial pressures. Accordingly, during this period Alpha was much preoccupied with financial performance, monitoring and resource choice, all of which were beset by profound uncertainty. Whilst the policy *Managing the New NHS* (NHSME, 1993) represents a logical and desirable development, its timing is problematic. Alpha faces a further merger - announced little more than a year after the Authority had previously reinvented itself - which has had a significant impact upon morale, resource allocation and policy continuity.

- Chapter 16 -

Case Study Beta

This chapter sets out the findings from the second of three case studies undertaken as a part of this research.

16.1 The Nature and Context of Beta Health Authority.

Beta is a Health Authority headquartered in an urban setting purchasing health care for a population of 309,000 spread throughout a geographical area of 38 square miles. The population served is richly diverse in terms of social class and ethnic mix and is located across three towns, some smaller concentrations and in their surrounding areas. The purchasing allocation is some £101m of which £1.5m is spent on commissioning. The Authority employs a staff of around 50.

Beta Health Authority - although retaining a separate legal existence - was, at the time of the initial and subsequent visits, a partner with the local Family Health Service Authority in 'Beta Health', an informal Health Commission. The configuration is the result of a commitment to work in partnership, to engage in joint purchasing and to move, together, towards the reforms set out in *Managing the New NHS* (NHSME, 1993). Although the NHS & Community

Care Act 1990 provides for a DHA board of a Non-Executive Chair, five Non-Executive Directors and five Executives (which must include the CEO and Director of Finance), at the time of the initial visit (in the summer 1994) there were vacancies for one Executive and two Non-Executive director vacancies. The Authority did not wish to appoint a fifth Executive but rather - given the certainty of a formal merger with the Family Health Service Authority - wished to retain an Executive vacancy and thus the option to offer it to the Family Health Service Authority General Manager in due course. The board therefore consisted of a chairman (a solicitor and Local Government Councillor), three Non-Executives (a local headmaster, a senior manager from the local TEC and the Chief Officer of the Local Council for Voluntary Services) and four Executives (the CEO, Director of Finance, Director of Public Health and a Director of Corporate Policy). Of the eight strong board, three were women (one Executive, one Non-Executive and the Chair); all were white.[1]

The board generally, but specifically the Chair and the CEO, appreciated the growing importance of corporate governance. This stemmed from the NHS scandals (see Chapter

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[1] The Authority had previously had a black woman Non-Executive Director who had performed well and been greatly valued by her peers. As an employee of a Local Authority, however, her employer had sought to pressure her to take a particular stance on a number of politically sensitive issues. This she resisted. Pressure continued to be exerted, however, obstacles were placed in her path and eventually she felt she had no alternative but to resign from Beta.

4) and the consequent publication of the NHS Codes of Conduct and Accountability (DOH, 1994), three months prior to the initial case visit - "we are very aware" (Chair). There was a genuine desire to respond to growing expectations and to operate effectively as a board.

16.2 Director Interviews: The Initial Case Visit

The director interviews were semi-structured and used an interview schedule which reflected the logic of Tricker's model of corporate governance (1984; also Hilmer & Tricker, 1990) and the areas explored in the postal survey - see Appendix 3. This was the framework which guided the exploration of local thinking and the practice of corporate governance in the *given* setting.

15.2.1 Direction The Authority appeared to be reasonably clear about its purchasing responsibilities but perhaps less certain of its role as a board. The Executive was seen to be "moving towards greater clarity" (NED) and Non-Executives as "finding their feet" (NED); also "members [engaged in] differing levels of debate... at times concerned with how far we as officers can go" (CEO). That said, Beta had established a clear mission and six key values which were used to shape both strategy and purchasing choices - see **Fig 16.1.** A clear view of what the key strategic issues were emerged during the initial interviews - one was concerned with "looking at outcomes" (CEO) and with "the use of Beta's influence to shape a

Fig 16.1
The Key Principles of Beta Health Authority

Mission

To use our resources and influence to improve the health of the residents of Beta

Values

Equity and Social Justice The strategy should be fair and impartial, with ready access to services available to all residents according to need. The strategy should be concerned with maximising the benefits of the health care system to the individual through the setting of communal objectives.

Appropriateness and Acceptability The strategy should focus on meeting identified health care needs in ways which are responsive to demographic, social and technological change and which are acceptable to the residents of Beta.

Efficiency and Effectiveness The strategy should be informed by a concern for efficient, value for money and high quality services which can be demonstrated to be effective by reference to a developing set of outcome measures.

Caring for People The strategy should be unashamedly concerned with the welfare of Beta residents; it should reflect their views and be explicit and open in terms of what can and cannot be delivered within the resources available.

Working Together Recognising that the DHA or FHSA cannot themselves effect changes in all influences on health, they should jointly seek to develop alliances and share information with other agencies (statutory, private and voluntary).

Balancing Care Within the NHS the achievement of better integration and balance between primary, community and secondary care services will be a prime strategic objective.

Source: Beta Authority - Purchasing Plan 1994/95

wider health agenda" (Chair; also CEO). There was also a desire to develop, a "locality purchasing" focus (Chair) in five distinct centres of population. As to member involvement a number of views were expressed which conveyed very different perceptions. One view tended towards directors playing a "corporate role" (Chair), another to them playing an emerging role (NED) and a further view saw them perhaps more narrowly concerned with the specifics and detail of contract monitoring or the regulation of Nursing Homes (Exct). This diversity betrays both some lack of cohesion and the 'growing pains' of a board, the membership and role of which was still in transition.

16.2.2 Executive Management Generally, there was clarity between the role of the Chair and the CEO although there was a recognition that the Chair spent a substantial amount of time on Authority business each week and "perhaps did trespass at times" (Chair). The relationship between the two - indeed between the Non-Executives and Executives generally - did at times seem tense which, although being "worked through" (Exct) - appeared to be the legacy of earlier patterns of working and, in some measure, the influence of Local Authority officer/member relations. Despite this, relationships at a personal level were "good", with the Chair focusing particularly upon the "press and political interface" (NED).

Although the physical preparation of the agenda was the responsibility of the executive, all directors were "free" to place items on the agenda (Chair), although few Non-Executives appeared to do so (CEO). Indeed at each meeting of the board there was an agenda item concerning "forthcoming items" when upcoming issues were signalled and additions offered or invited (Exct). Decision making was by "consensus" (NED), in which a shared view "emerged" (CEO), or, with the Chair "taking the mood of the meeting" (Chair).

Executives were seen to be making "some degree of adaption" (NED) from their previous role, indeed one director described his own experience as "initially quite strange" (Exct). A particular example is that of the role of the Director of Public Health who is required, simultaneously, to play a corporate role as an Executive, yet at times take an independent/professional stance e.g. in respect of the publication of *her* annual report. Transitional difficulties such as these were thought to be due to the fact that the development of Executives had been "somewhat overlooked" (CEO) in favour of the Non-Executive role.

16.2.3 Supervision Beta had given serious consideration to the role of a 'Company Secretary' which one director had been "pressing for" (Chair), a proposal for which was included in the "merger structure" (CEO). The size of the

Authority, however, was seen to be such as to require only a part time appointment and was envisaged as a "detached" role (NED). At the time of the initial visit there was little or no committee infrastructure, although an Audit Committee had been established in the Spring of 1994, and a Remuneration Committee was soon to be constituted.

The quality of information necessary to facilitate monitoring and strategic control was seen to be acceptable... "most of the time" (Chair). Non-Executives had a prior opportunity to consider their papers from the "monthly posting", much of which was orientated towards "exception reporting" (CEO). Despite this the measures the board pursued to satisfy itself that its previous decisions had been implemented centred upon the formal minutes of their proceedings and associated action sheets. Whilst there is no suggestion that implementation was anything less than complete, *board* action was unsystematic and incomplete and at least one director saw this as "an area of concern" (Chair). There was clearly a need for a system which would allow a "more explicit" (NED) review of decisions and targets. In terms of individual directors, the performance of Non-Executives was not formally reviewed but the Chair would "take them aside" (Chair) if there were any difficulties; their performance was, however, considered carefully and more explicitly when renewal was being considered towards the end of a Non-Executive's term. Executive performance was managed via the Individual

Performance Review (IPR) appraisal system, although it was anticipated that this process would widen as the Remuneration Committee established itself. Beta had no explicit ethical framework other than its mission and values and there were no significant conflicts of interest.

16.2.4 Accountability Beta did have a mission statement and explicit values although these did not explain either to whom, or how, the Authority was accountable. One director expressed the view that the Authority "should account to the local community", but saw some conflict between "continuity and accountability" - the only solution residing in democratic election (NED).

The Authority met on a monthly basis alternating between public and "closed" meetings (Chair) which took the form of "workshops or seminars" (Exct), some with the Family Health Services Authority. The public meetings rotated around the borough but aside from staff, interest groups and the media were not well attended. In addition, the Chair and Non-Executives met together twice a year; the Executives also met, but more frequently and more informally. Beta published an annual report by the Director of Public Health, a community newspaper and a conventional Annual Report.

Beta had no formal policy statements setting out its position towards key stakeholders. That said, it had developed an implicit position towards some groups. Its mission and values were largely orientated towards the public, although they also contained important references to alliances with health and other bodies in furtherance of its objectives. In addition, its co-existence and co-location with the Family Health Services Authority was a very powerful symbol. The two groups least obviously addressed were providers and the Authority's own staff.

16.2.5 Key Influences When directors were asked if they understood their statutory obligations and legal responsibilities a varied picture emerged. The Chair clearly did so, but the knowledge of Non-Executives was thought to be only "near complete" (NED). Executives were believed to understand such matters well but they were "less certain" of the Non-Executive's understanding (CEO). In terms of induction, some provision was available for Non-Executives but was less certain for Executives.

There was little in the way of social contact between board members outwith formal board meetings and seminars. Exceptions to this were appointments and retirement functions and some visits. Interviewees were commendably aware of the financial sensitivities of such contact but less alive to the opportunities to increase understanding and strengthen relationships. Although relationships were

described as "open and friendly" (Chair) there did appear to be a "healthy tension and business distance" (NED) between the Non-Executives and the executive. Whilst this may be seen as functional in terms of the supervisory dimension of governance it may inhibit the cohesion and shared understanding necessary for shaping direction and exercising executive management.

16.3 Director Interviews: The Second Visit

The second visit interviews involved only the Chair and CEO in each case study site and the brief account which follows adopts an 'exception reporting' convention, picking up only important differences and developments, or the lack of them. In the case of Beta (visited in February, 1995) there was visible progress towards the merger of the Health Authority and the Family Health Services Authority. It had been apparent to both Authorities for some time that such a merger was both likely and desirable. This shared view spawned a political and organisational commitment to work, together, towards the goal of a new single Authority. Indeed it was this commitment which had earlier led to their co-location. At the time of the second visit - although separate and sovereign Authorities - operating systems and patterns of working were becoming increasingly integrated (CEO), the Health Authority CEO had been appointed as the "Joint Chief Executive" (Chair) and the Authorities each sent observers to one anothers meetings in

addition to the joint meetings which took place. Unlike Alpha, further NHS reform (NHSME, 1993) had not becalmed but invigorated its efforts. Beta was not standing still but moving forward largely on its own initiative.

Beta did not appear to be experiencing any particular financial pressures, indeed there was some optimism that the local area might be given "regeneration status" which could attract an additional £13m of further funding (CEO). The strategic position of Beta therefore appeared buoyant and the directors rather more optimistic, with steps being taken to develop a revised and joint strategy. The growing importance of Primary Care - itself the subject of an externally facilitated member seminar - was likely to feature prominently in the revised strategy (CEO). Since the initial visit one Non-Executive had departed, one had been appointed and one vacancy remained; the original Executive vacancy also remained.

In terms of overall direction, attention was shifting towards Provider performance with which there was some dissatisfaction; also towards the reconfiguration of Acute Services. Some tension still appeared to exist between both sides of the board, although the Executive directors seemed more at ease with their roles. Beta had published an Annual Report which contained information concerning directors' remuneration; it also had Audit and Remuneration Committee(s). Although there had been "a number" of

conflicts of interest (CEO), these had not been serious and had been dealt with openly. The board had experienced "several" facilitated member seminars, some "focused" (e.g. Primary Care) and others concerned with "process" (e.g. Non-Executive director development).

16.4 The Directors of Beta Observed

The board of Beta was observed on three separate occasions: at two meetings of the Authority in public (both the public and private parts of the agenda on each occasion) and at a special and private meeting of the board with the Executives of the local Acute NHS Trust.

In terms of the meetings of the Authority in public each meeting had been publicised and on both occasions took place during the afternoon in the headquarters building of Beta. To attend the meeting one had to present oneself at reception, sign in, gain entry via a locked security door, negotiate a lengthy corridor, locate and enter the meeting room. The seating arrangements were formal with those present seated around a square arrangement of tables with the Chair (and the CEO at her side) with their backs to the light and facing the door. Sat around the table was the board with Executives and Non-Executives mixed together, and, furthest from but facing the Chair, Family Health Service Authority and Community Health Council representatives. The press and public numbered between three and four on both occasions.

At both meetings a conventional agenda was pursued - apologies, minutes, matters arising, chairman's communications, prime items of business and circulars - followed by the private part of the agenda from which the press and public were excluded. The principle variable was the number of business items which, as it happens, proved to be five at each meeting. Of these ten business items: seven took the form of reports being presented, one was an item which was tabled and two were for decision. In terms of the items for decision, one was to confirm an earlier decision taken by the Executives and the other item was, in the event, deferred for further discussion and subsequent decision. Although the business conducted was wide ranging it centred upon a number of themes:

* monitoring purchasing and service quality
* monitoring resource use, and,
* discharging statutory functions.

The first of the meetings was complicated by the fact that no Non-Executive attended the meeting other than the Authority's Chair, which was thus inquorate. Although the Chair managed the circumstances well and chaired the meeting with considerable *savoir-faire* there was little real debate as Executives filed on to 'talk to their item'. The second meeting was well attended and therefore rather more animated, but, both meetings at times got drawn into detail at the expense of a more strategic perspective. Both

meetings looked and felt like formal meetings of a public Authority, rather than business meetings of a board. Although there was an opportunity at each meeting for questions from the public, these were few and far between.

In some contrast to these meetings was the meeting between the board and the executive of the local Acute NHS Trust. The Trust team wished to present to and discuss with the board their corporate investment strategy. In essence this was to involve "condensing and concentrating" (Trust CEO) services - in short moving from six to much fewer sites. The presentation/debate ranged over the rationale, options, costs and benefits, and, the impact upon service provision, jobs and the local economy. The board were generally supportive except for one Non-Executive who appeared to have serious and sincere reservations. The Trust team were eventually asked to withdraw, the board debated the case which had been presented and - subject to there being no residual anxieties following further discussion with the 'sceptical' Non-Executive - supported the Trust in taking their proposals forward.

The comparison between the two regular meetings and the special meeting was striking. The regular meetings of the Authority were very much the public face of the board at work with carefully prepared papers and discussion. The public sessions, particularly, were marked by a cautious approach, the use of measured tones and careful discussion.

These sessions could perhaps be renamed press rather than public sessions since directors appeared very conscious that an innocent phrase could easily be misinterpreted - intentionally or otherwise - into a controversial 'sound bite' headline. Although there had been instances where this *had* happened in the past, such events seemed to have a disproportionate influence upon the manner in which the board conducted its business in public. The private part of these meetings - usually concerned with personnel or commercially sensitive issues - was more relaxed, open and animated. Directors were less guarded which was apparent in their demeanour and in the way in which they carried out their duties.

The meeting with the executive of the Acute NHS Trust was different again. If the regular meetings were those of a public Authority discharging its responsibilities, this meeting was the board at work and doing business. The Trust team were clearly seeking the support of their Purchaser for their capital strategy, which was evident from the care they had taken in their preparation and in the rigour of their presentation. The board for its part - although keen to encourage its principal Acute Provider - was not about to simply rubber stamp their proposals. It was evident that this was not the first discussion of these matters but it was to be the last, at this stage. The debate was real and the outcome mattered. The board listened to the presentation, asked detailed questions and were clearly

sensitive to the impact of the proposed rationalization upon both the continuity of service provision and upon the effects upon the local community. Executives and Non-Executives played a full and equal part and one had a real sense that a critical decision was being taken. In the event the board was persuaded that the Trust's proposals should be supported.

16.5 Reflections on the Board of Beta

In common with the boards of other NHS bodies, Beta demonstrated areas of both considerable strength and some weakness. In terms of their **strengths**, Beta has derived considerable strategic advantage from its attitude to and position on the merger of themselves and the Family Health Services Authority. As noted above, this has been a joint policy goal for some time, with progress towards implementation being ahead of objective necessity and in advance of most of their contemporaries. When the formal merger does take place in the Spring of 1996 this will represent the culmination of such a course. For Beta it will be a beginning and not, like Alpha, the end. Clearly individual directors and the board itself have played an important part in this process, a part entirely in keeping with their governance role of providing strategic direction.

In common with Alpha the quality of information provided in support of monitoring and control was recognised as still evolving, an exception being the financial reports which were presented to the board and were of a very high standard. They were brief, contained essential figures and some explanatory text and each of the five sections - on cash limits, contracts and reserves, losses and compensations, trust funds and with the headquarters budget - contained specific recommendations. In addition, the report was well presented and questions competently and fully addressed. One was left with a sense of effective control and a high level of financial rectitude.

The **weaknesses** identified here largely represent unexploited opportunities rather than any absolute failure to achieve an acceptable level of performance and can be thought of in terms of process, task and external relations. In terms of process, there is some lack of clarity concerning director roles - both to the incumbent of such roles and in the views Executives hold of Non-Executives and vice versa - and, in both cases, having a clear understanding of their statutory obligations and legal responsibilities. This lack of clarity appears to fuel some of the underlying tensions between directors. Paradoxically one area of difficulty was the perspective brought by some directors to the deliberations of the board. Both Executives and Non-Executives, often in

combination, were involved in the inspection of both Nursing Homes (a statutory obligation) and of Provider organisations (in pursuit of service quality). Whilst it is for the board to decide how to best address such needs, there was at times lengthy and detailed consideration of the reports emanating from such activities. Clearly there are times when detail does need to be considered but if this is often or always the case, the bigger picture of the particular issue and the strategic orientation of the board, more generally, may be obscured by detail.

In regard to the task domain an area of some concern was the lack of a systematic and explicit process by which the *board* satisfied itself that the decisions it had taken had been implemented and, where appropriate, in a manner and to the time table agreed. A failure to demonstrate this seriously undermines a board's capacity to exercise its supervisory responsibilities - the issue at the heart of <u>all</u> of the NHS governance scandals.

In terms of external relations, it was striking that the Authority had no explicit position statement concerning its stance on and attitude towards key stakeholders e.g. the public, providers, its own employees and other NHS bodies. This is not to suggest that these matters had gone totally unconsidered for the strategies pursued by Beta were very clearly population focused and actively sought to work with NHS and other bodies.

However, there was no coherent, explicit and systematically pursued course in regard to stakeholders which unnecessarily diminished the pattern of governance pursued by Beta. An example of this is perhaps the paradoxical attitude of Beta towards the community. There is not the slightest doubt that people are at the centre of Beta's thinking, its purchasing intentions and contracting. Yet when it comes to opening themselves to public gaze, its deeds do not match its aspirations. This is not to suggest that Beta actively excludes the public from its meetings, quite the reverse. However, the public would require both knowledge and some considerable determination to seek out and observe the board at work on its behalf.

- Chapter 17 -

Case Study Omega

This chapter sets out the findings from the third of the case studies undertaken as a part of this research.

17.1 The Nature and Context of Omega Health Authority.

Omega is a Health Authority headquartered in the metropolitan environment of a major city purchasing health care for a population of 574,000. The population is richly diverse and displays all the variability one has come to expect from the rich social, economic and racial mix found in a range of settings spanning inner city living to leafy suburbs. The purchasing allocation is some £220m of which £3.5m is spent on commissioning. The Authority employs a staff of 74.

Although the NHS & Community Care Act 1990 provides for a DHA board of a Non-Executive Chair, five Non-Executive Directors and up to five Executives (which must include the CEO and Director of Finance), at the time of the initial visit (in autumn 1994) there were two Executive and one Non-Executive director vacancies. An appointment had been made to one of the Executive vacancies but the individual was thought to lack the experience and therefore, although appointed to the role, was not

appointed as an Executive director. The view was taken that he would be developed, allowed to accrue further experience and a decision upon his Executive status reviewed at a later date. The remaining Executive vacancy was to be held in abeyance. The board therefore consisted of a chairman (a former industrialist and a person active in public life) four Non-Executives (a partner in a major consultancy firm, a partner in a law firm, a former banker and a local headmaster) three Executives (the CEO, Director of Finance and a Director of Public Health) together with a senior manager carrying the Director of Consumer Affairs brief. Of the nine, three were women (one Executive and two Non-Executives), one Non-Executive had some degree of disability and one Non-Executive was black.

The board generally, but specifically the Chair and the CEO, appreciated the growing importance of corporate governance. This stemmed from the NHS scandals (see Chapter 4) and the consequent publication of the NHS Codes of Conduct and Accountability (DOH, 1994), six months prior to the initial case visit and was seen as "a legitimate concern" (Chair) and "an issue of substance" (CEO). The Cadbury Report (Cadbury, 1992) was seen to have provided a critical impetus and created the conditions in which corporate governance could be "held up to the light" (NED) There was therefore a genuine desire to respond to growing expectations and to operate effectively as a board.

17.2 Director Interviews: The Initial Case Visit

The director interviews were semi-structured and used an interview schedule which reflected the logic of Tricker's model of corporate governance (1984; also Hilmer & Tricker, 1990) and the areas explored in the postal survey - see Appendix 3. This was the framework which guided the exploration of local thinking and the practise of corporate governance in the *given* setting.

17.2.1 Direction Any consideration of the issue of direction needs to be prefaced by the fact that the Authority was only six months old at the time of the initial visit. This was because it had only come into existence on the 1st April 1994 and was the result of a merger between three former Health Authorities - described by the CEO as a "curious and uncertain" process. The composition of the board reflected something of this history with some Executives and Non-Executives being drawn from former Authorities, whilst others were new appointments.

The history and composition of the board - a forming executive together with two Non-Executives with no NHS experience - was such that issues of direction were just beginning to emerge. There was no clearly articulated or shared sense of purpose but some initial thoughts had been drafted "although brief it is still too long... with a bias toward *what* rather than *how* business is to be conducted"

(NED). This and the identification of the key strategic issues had been the focus of a recent facilitated away day for the board. The systematic involvement of members was, however, "still unfolding" (NED). There were "private alliances" between Executives and Non-Executives on an "informal issue basis" (Chair) which was welcomed by the executive and clearly favoured over Executive shadowing (CEO). There was a clear recognition that the agenda of a Health Authority was set both centrally and locally. Government priorities were likely to be influential but there was also a recognition of the need to address specific local needs. As a consequence some tentative thoughts had been given to some form of "locality" focus (CEO) and thus a "geographical" rather than a "functional" alignment for Non-Executives (CEO). The extent to which this could be taken forward was seen to depend on dialogue with the community, consultation and market research.

17.2.2 Executive Management There was clarity between the role of the Chair and that of the Chief Executive. The Chair was seen to have a "boundary spanning role" concerned with taking "the overview" (NED), with "managing upwards" (Exct), yet an active involvement concerned with "making things happen" (Chair). By contrast the Chief Executive was seen to be concerned with managing the executive team and creating "an extrovert culture" (Exct). Each role complemented the other and they were seen to have a "close and working relationship" (Chair).

The preparation of the agenda was jointly undertaken by the Chair, CEO and the Secretary to the Authority, other directors being free "in principle" to add items, although this normally arose in the course of boardroom debate (Chair). Decision making was largely by "consensus" (CEO), options having been developed in the course of discussion (NED) - there had been no votes in Omega's (admittedly brief) history (Chair). It was also clear, however, that there was a desire to avoid "being taken by surprise" (Chair). Executives were seen to have "some way to go" (NED) in developing their corporate role, in particular the Director of Public Affairs (see above).

17.2.3 Supervision Despite its comparative youth Omega had appointed a 'Company Secretary', the former Director of Administration from one of the three predecessor Authorities. Although the post holder was closely associated with the executive he was perceived as occupying an "independent" role (Exct). At the time of the initial visit Omega had established Audit and Remuneration Committee(s), although there were doubts about the latter and the extent to which it could actually influence events (Chair)[1]. There was also a desire to establish a Quality committee but this was still the subject of discussion and was evolving organically.

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[1] At the time of the fieldwork, the discretion open to DHA Remuneration Committees was considerably less than that available to their counterparts in NHS Trusts.

The quality of information necessary to facilitate monitoring and strategic control was seen to be in need of some improvement - "it needs to be better" (NED). Financial reporting was considered satisfactory but activity information - largely furnished by Providers - was "poor" (Chair). A major project designed to integrate information technology and harmonize information types and sources was seen to be the longer term solution.

The measures the board pursued to satisfy itself that its previous decisions had been implemented centred upon the role of the Company Secretary and upon formal minutes and associated action sheets. In addition, the Audit Committee also appeared to exercise an overview but despite such efforts "more needs to be done" (NED). In terms of the performance of individual directors, Non-Executive performance was not formally reviewed but it was the intention to do so (Chair). Executive performance was managed via the Individual Performance Review appraisal system; the Remuneration Committee also took an interest in matters of performance and reward. Omega had no explicit ethical framework but it had adapted a modified version of the Standing Orders and Standing Financial Instructions from one of the three predecessor Authorities as an initial step. There were no reported conflicts of interest in Omega. The board had taken great care in regard to Omega's dealings with a major consultancy and in establishing the Authority's banking arrangements given the background of

two of Omega's Non-Executive Directors i.e. a senior partner of the former and a former bank executive.

17.2.4 Accountability Omega did not have a fully developed or agreed mission statement and therefore no statement of accountability, although it was assumed that the "public sector ethic" of "accountability to the local community" would apply (NED). In any event such matters would be informed by national codes (CEO). Interestingly one director suggested - somewhat light heartedly - that in reality the Authority was perhaps really accountable to the media !

The Authority met on a monthly basis alternating between public and private meetings, the latter in "seminar format" (Chair). The public meetings were held in Omega's headquarters - the morning taken up in preparation for the afternoons public meeting which was held in the presence of a "hostile media" (NED). The press and public were, of course, free to attend the public sessions but Omega did not seem to enthusiastically encourage attendance, with only two or three individuals attending a typical meeting. Omega had published a report by its Director of Public Health, its own tabloid newspaper *The Health Line*, and, intended to publish a conventional Annual Report in due course.

Omega had no formal policy statements setting out its position towards key stakeholders. That said, implicitly it had a developed position towards some groups. In common with other District Health Authorities it was assumed that an orientation towards the public was self evident - and while this was certainly reflected in some of their documentation e.g. the draft 1995/96 Purchasing Plan - it cannot be assumed to be the case. In terms of NHS and other bodies Omega was keen to work closely with Social Services and to engage in "joint commissioning" (CEO), but again, not explicitly so. In fairness, it was probably too early in the life of Omega for the board to have a fully thought through position, but it was their intention to reflect the nature of such critical relationships in the mission statement (CEO). The two groups least obviously in the minds of Omega's board were other NHS bodies and their own staff.

17.2.5 Key Influences When directors were asked if they understood their statutory obligations and legal responsibilities a varied picture emerged. Executives were confident of their understanding (CEO) but Non-Executives were only seen to be "learning" and that it was important to be able to distinguish between "the apparent and the real" in this area (CEO). This latter point was borne out by the Non-Executives themselves when conceding that their knowledge was "not enough" (NED). Little existed in terms of formal induction - less in the case of Executives (CEO)

- but seminars were an opportunity for shared learning as were facilitated events.

There was little in the way of social contact between board members outwith formal board meetings and seminars which appeared to be something of a missed opportunity and strangely at odds with "board to board dinners" (NED) which took place between Purchaser and Provider interests. Despite this, relationships were "good and developing" (NED). A rather more cautious note was struck by other directors: "its early days... keen not to perpetuate us and them" (Chair) and relationships seen as "an evolving dynamic" which would only really be tested in conditions of "crisis" or when faced by extreme, perhaps contradictory, policy choice (CEO).

17.3 Director Interviews: The Second Visit

The second visit interviews involved only the Chair and CEO in each case study site and the brief account which follows adopts an 'exception reporting' convention, picking up only important differences and developments, or the lack of them. Perhaps the most striking difference in Omega was the context and mood of the organisation which was strikingly different between the first visit, which took place in September 1994, and the second visit in January 1995. Although the board of Omega had only recently been established and much was still to be done, one was struck

by an almost palpable 'buzz' in the organisation. Those interviewed conveyed a sense of excitement and vibrancy and - not withstanding the comparative youth of the organisation - approached their task with a determination to shine, both as a board and as a Health Authority. At this time one was conscious of the completion of managerial appointments, new arrivals could be seen unpacking as accommodation was allocated and - literally - the smell of wet paint could be scented on the air. Only four months later the circumstances were profoundly different.

Omega, in common with other Health Authorities - and consistent with the requirements of continuing reform within the NHS (NHSME, 1993) - was preparing to merge with a neighbouring Health Authority and with the Family Health Service Authority. Whilst senior figures clearly appreciated that this was inevitable this did not appear to be the perception of the board as a whole. When, subsequently, the intention to create a new-style Health Authority was formally announced - with the Chief Executive of the neighbouring Authority being appointed as the "project manager" and the same Authority's Chair being identified as the "lead Chairman" - the board of Omega was visibly stunned. Senior directors appear to have been greatly disappointed that they were not to play a more prominent part in future events, whilst other members of the board appear to have been taken almost completely by surprise. The sense of momentum, growth and optimism was

transformed into dejection and despair. This was in part a response to the practical and organisational consequences of the proposed change - the return of uncertainty, further (re)appointments and, again, relocation - and in part a sense that the failure to secure structural influence condemned it, as a board, to extinction. Omega had been fatally wounded.

In the course of the interviews it became clear that progress in other areas had been made in advance of, yet now over shadowed by, the events described above. Omega was getting to grips with resource matters: in particular some concern was emerging concerning a short term overspend of £300,000 on extra contractual referrals and an underlying "inherited and technical" (Chair) deficit of £6m. The former represented a "pressure" which it was intended would be managed "in year" by a transfer from reserves, the latter the subject of protracted and ongoing debate with the Regional Health Authority (CEO). In terms of direction a much clearer view was evident which centred upon the need to develop primary care purchasing, and, to continue to purchase Acute and Mental Health provision whilst the services concerned were themselves being rationalized. This broad approach was supported by and consistent with the Authority's key "principles" - see **Fig 17.1** In addition to Audit and Remuneration committees a Quality committee had been established and an Annual Report published.

The membership of Omega's board was also beginning to change. The Director of Finance had been appointed as Finance Director to a nearby Trust and his departure was imminent. The position of the Director of Public Affairs remained unaltered and the outstanding Executive vacancy was not to be filled. The one Non-Executive vacancy - which had been the subject of discussion with the local University as to a suitable nominee - was also to be held in abeyance. The board therefore consisted of a Chair, four Non-Executive directors, the Chief Executive, a departing Director of Finance, a Director of Public Health and a senior manager as the Director of Public Affairs. The change in context and mood was matched by a changing cast list in the boardroom.

Fig 17.1
Omega Authority - Purchasing Principles

Services purchased by Omega should:

1 improve the health of individuals and the population

2 be of high quality

3 be efficient, providing value for money and maximising the number of people who can receive the services they need, and,

4 be available equally to everybody on the basis of clinical need.

Source: Draft Purchasing Plan 1995/96, Omega Health Authority

17.4 The Directors of Omega Observed

The board of Omega was observed on three separate occasions: at a meeting of the Authority in public on two occasions and at a private "preliminary meeting" prior to the second of the above meetings.

In terms of the meetings of the Authority in public one was observed on the occasion of each case visit. Each meeting had been advertised and on both occasions was held in Omega's headquarters building. To attend the meeting, however, one had to present oneself at reception, sign in, gain entry via a locked security door, locate and enter the ground floor meeting room - a process likely to deter all but the most determined. The seating arrangements were formal with those present seated around a square arrangement of tables. The Chair sat with his back to the light opposite the senior Executives and the Vice Chairman, with the remaining members of the board arranged around three sides of the square table. Guests at the meeting - which included Community Health Council representatives with "observer status" (Chair) - could sit at the table (on the axis to the right of the Chair), the press and public - normally between 2-4 in number - in separate seating behind these places.

On both occasions the agendas reflected the conventional logic: statutory business, District Health Authority, management, contracting and other items on the

first occasion; District Health Authority, management and other items at the second meeting. There were fourteen substantive items of business on the first agenda and seventeen on the second. Of these thirty one prime items of business - 1 was a Public Health presentation, 15 items were for decision and 15 were reports which were received/ noted. Although the business conducted was both substantial and wide ranging it was clustered in a manner appropriate to a Health Authority (see agenda logic above) and, reflected a range of specific themes:

* monitoring resource use
* monitoring purchasing and contract performance
* determining strategy/strategic relationships, and,
* discharging statutory functions.

Both meetings looked and felt like the meeting of a board - but a board reflecting the conventions of its public sector antecedents and one somewhat ill at ease with having to conduct its business in public and in the presence of the press. There were no formal opportunities for the public to raise questions. In short, the style was somewhat cautious. That said, the meetings were extremely well chaired, great courtesy was shown to guests and the interaction between directors themselves was constructive and supportive. If there was a division within the board it existed between those who had a private sector/commercial background and those who did not, rather than between Executives and Non-Executives.

The third opportunity to observe the board at work was at the "preliminary meeting" prior to the second of the above meetings. The purpose of the gathering being to consider the agenda for the public meeting and to deal with any 'matters of the day'. The content of the meeting matched the afternoon's agenda in every particular which - although not a rehearsal - was an opportunity to identify key points, signal contentious issues and generally to pre-digest the business. Whilst functional in the sense that the subsequent meeting ran smoothly it lacked some spontaneity and - particularly the second meeting - a degree of conviction. Any difference in conviction, however, was more likely to be a reflection of Omega's changed circumstances than the effects of funnelling.

17.5 Reflections on the Board of Omega

In common with the boards of other NHS bodies, Omega demonstrated areas of both considerable strength and some weakness. In terms of their **strengths**, the most obvious manifestation was the business-like approach that Omega brought to the conduct of its affairs. This was not merely good quality papers and well managed meetings but a real sense in which the directors acted as a board rather than a public authority who had a new vocabulary but the same behaviour. Some indication of the board's performance can be judged by the prodigious number of prime items of business and the high proportion of items for decision at

each meeting. Sound leadership and high calibre directors created such a climate and the promise so evident on the first visit. Although never fully realised, Omega also showed early signs of bringing some degree of innovation to the purchasing of health care.

The **weaknesses** identified here largely represent unexploited opportunities rather than any absolute failure to achieve an acceptable level of performance and can be thought of in terms of process, task and external relations. In terms of process, the directors of Omega had a better than average understanding of their respective roles. However, the fact that there were (latterly) only three substantive Executives on the board, one of which came from a business background, meant that the executive was less powerful and less influential as a consequence. This is not to suggest that the executive should dominate, but the board did require more balance. In the event, circumstances changed before any potential difficulty could arise. In the task domain, although there was some concern about the implementation of decisions, this was less problematic given the appointment and contribution of the 'Company Secretary'.

In terms of external relations, it was striking that the Authority had no explicit position statement concerning its stance on and attitude towards key stakeholders e.g. the public, providers, its own employees and other NHS

bodies. This is not to suggest that these matters had gone totally unconsidered for the strategies pursued by Omega were very clearly population centred and actively sought to work with other agencies. However, there was no coherent, explicit and systematically pursued course in regard to stakeholders which unnecessarily diminished the pattern of governance pursued by Omega. An example of this is perhaps the paradoxical attitude of Omega towards the public. There is not the slightest doubt that people are at the centre of Omega's thinking, its purchasing intentions and contracting. Yet when it comes to opening themselves to public gaze, its deeds did not match its aspirations. This is not to suggest that Omega actively excluded the public from its meetings, quite the reverse. However, the public would require both knowledge and some considerable determination to seek out and observe the board at work on its behalf.

- Chapter 18 -

Reflections upon the Case Studies

18.1 A Comparison of the Case Study and Survey Findings

This chapter provides a broad comparison of the survey and case study findings to establish the extent to which the latter:

* complements and validates the former, and thus,
* the extent to which the actual behaviour of directors mirrors or differs from their self reported attitudes and experience.

18.1.1 The Characteristics of Directors The survey data painted a picture of the boards of Health Authorities being populated by white (96.7%) middle aged (and mostly) men (72.9%) - with membership being characterised by continuity rather than change. Although the survey findings suggest that the position of women is improving, the case studies suggested rather more active progress, due in part to positive action, and, to less hostile male and institutional attitudes. Indeed, all the case study boards had at least two female directors although (outside the field of Public Health Medicine) female Executives remain few. By contrast black directors were represented in small numbers in the survey (3.3%) and in comparable numbers in the case studies. Only case study Omega had a black Non-

Executive director (although Beta had previously had a black Non-Executive), but none of the case study boards had a black Executive.

The impression of continuity rather than change to arise from the survey was only partially reflected in the case studies. In all three cases the Chair and Chief Executive, and, in two of the case studies, a number of Executives had been in their present role/post for some time. By contrast Non-Executives were a less stable population with new directors having been appointed either as a consequence of the reforms or to replace resigned or deceased predecessors. All three Chairs confessed to difficulty in finding suitable Non-Executives - of any colour! For this reason - and because of further reform - all the case study boards had at least one Non-Executive vacancy. In addition, none of the case study boards had a full complement of five Executives - typically they had four (CEO, Director of Finance, Director of Public Health, and one other).

This seemed to be a conscious choice and motivated by the prospect of further reform and 'politically' by the need to allow for a place on the board following merger with the Family Health Service Authority. Other factors may include difficulty in identifying a suitable person/clear case for the fifth Executive or to 'strengthen' the Non-Executive element of the board by appointing fewer

Executives. Whilst a case can be made which explains the smaller number of Non-Executives and Executives than expected - and there may be short term local and/or financial advantage in such a circumstance - ultimately it must reduce the amount and diversity of talent available to the board. In addition, power is concentrated in fewer hands. Neither is desirable.

18.1.2 Direction The survey data depicted a situation in which the majority of respondents reported the existence of a mission (84.6%) which reflected organisational values (79.1%) but not to whom and for what the Authority was accountable (61.6%). The extent to which the board regularly reviewed its own working style was also reported at a low level (48.5%). The case study data supports this picture. Two of the three case study authorities had a clear mission statement, all three had an explicit value set but none of the three had a clear or shared view as to who they were accountable to. This is not to suggest that the case study sites had not considered the matter, but rather, that a range of accountabilities were recognised, often implicitly and the priorities varied between both Executives and Non-Executives and between individual directors. The issue is therefore not one of neglect, but of primacy and coherence. In terms of the regular review of working style only Beta had undertaken a set piece review - largely prompted by its ever closer union with the Family Health Service Authority - the others had not. It is

important, however, to qualify this comment. Firstly, Alpha and Omega had both recently merged with other authorities and had not therefore existed long enough to prompt a major review and, secondly, changes in working style are normally more likely to be incremental.

When asked to identify the single most important strategic issue facing them, survey respondents reported commissioning services (36.4%), merger/boundaries (35.1%) and finance (20%). The experience of the case study boards mirrored this position almost exactly. All were concerned with commissioning - in particular with the impact of the reconfiguration of Acute Services - and all were moving towards dissolution/rebirth as a consequence of continuing NHS reform. As a discrete issue, finance had hardly featured in the pilot study but was identified by 1:5 in the main survey. In the case studies, Alpha and Omega were both concerned with financial matters: control over Extra-Contractual Referrals (ECRs) expenditure and, in the case of Omega, with a substantial underlying deficit. Financial matters had clearly become more important.

Survey respondents reported little systematic member involvement (51.4%). Despite Non-Executives taking a functional interest (e.g. accountants in matters of finance) or becoming identified with specific issues (e.g. Quality or Nursing Homes) there was limited evidence from the case studies of individual Non-Executives identifying

themselves with a *strategic* orientation. Whilst it is important for Non-Executives to avoid becoming 'lesser Executives' their contribution was, in this regard, diffuse.

The extent to which directors, particularly the Chair, play an active part in the life of the board is crucial. When asked if there was clarity between the role of the Chair and that of the Chief Executive 85.5% of survey respondents reported complete or reasonable clarity, although Executives/Non-Executives were more likely to be sceptical. Although the case study experience would tend to support this general contention, all three Chairs played an active 'hands on' role. There were some concerns about the Chair of Alpha who had previously taken robust unilateral action; the Chair of Beta who, by her own admission, tended to "trespass" and the Chair of Omega who simply exuded authority and presence. Both the personal qualities and the individual accountabilities of those concerned ensure the active involvement of Chairs and, as a consequence, some ambiguity concerning the focus and strength of leadership. That said, more than 85% of survey respondents felt they could challenge the Chair and influence their view or a decision. Again, however, Executives/Non-Executives were more likely to be sceptical. In the case studies it was evident that Chairs could be challenged, but, rather more by (experienced) Non-Executives than Executives. Although this was generally true for all the case sites it was

rather more likely in Alpha but rather less likely - in public session at least - in all three. Why should this be? It was evident in all the case study sites that there was some degree of discomfort with public meetings. As a consequence the temptation to manage a quick and uncontentious meeting is high. The danger, however, is that the role of the Non-Executive is perceived to be weak and that of the Chair strong, even dominant. This is potentially dangerous to the extent that it may reinforce (a distorted) view, or, *become* the pattern of board working.

18.1.3 Executive Management The survey data suggested there was ample opportunity (63%) to place items on the board agenda although some (23.5%) nearly 1:5, doubt this. Whilst this was essentially the case in all three case study sites, the reality was a little different, in so much as few Non-Executives appeared to *take* the opportunity to do so.

The survey showed that the bulk of the decisions were taken by means of consensus (86.3%). This was also found to be so in the case studies, but, there was a substantial difference between items requiring decision in Alpha and Beta on the one hand and Omega on the other. Some of this may reflect differences in context, or in the personality of the Chair, however, given the broadly similar nature of the task, one can only conclude that the difference is

largely one of style rather than substance.

Approximately two thirds of survey respondents reported playing a generalist role (63.3%) but, of those who did not, about 1:4 Non-Executives and 3:4 Executives reported playing a specialist role. The case studies also reflected this pattern. The survey clearly showed, in the view of the respondents, that 92% of decisions were made by the executive which is in marked contrast to the case studies. Directors in the case study boards were very clear that although day to day decisions were, of course, taken by the executive, major decisions were taken by the board, and, in all three cases a few specified decisions were reserved exclusively for the board. This difference might suggest that respondents, perhaps, misunderstood the survey question. A rather more convincing explanation, however, is the increasing emphasis upon supervision and the consequent decline in Executive 'freedom' which took place between the survey and the case studies.

18.1.4 Supervision 40% of survey respondents reported that consideration had been given to the appointment of a Company Secretary. This compared with the intention to appoint in Beta and an appointment having been made in Omega. The existence of board committees was not extensive with only 33.3% of survey respondents reporting their existence. The situation in the case study boards was mixed. Alpha had made the least obvious progress and Beta

and Omega each had an Audit and Remuneration Committee(s); Beta also had a Quality Committee. In both the postal survey and the case studies all or most had a clear mandate, although Audit Committees had most obviously taken root and were vigorously going about their business.

79.1% of survey respondents reported that the information provided to the board supported monitoring and strategic control. This was in marked contrast to the case studies where information was seen to be in need of improvement and as such a source of some concern. Generally, financial information was seen to be of the highest quality (especially Beta), but contracting/activity and quality were both poorer. Survey respondents reported that discussion was always or mostly frank (92%) which was confirmed in the case studies. It is important, however, to distinguish between the apparent and the real. Discussion was indeed frank, but, noticeably more guarded in public and in the presence of the press. This may easily lead to/reinforce the view that Health Authority meetings are both ritualistic and dominated by a strong Chair (or CEO).

In terms of board performance the survey revealed that only 56.3% of directors reported the existence of a mechanism to ensure the implementation of decisions. None of the case study boards had a formal mechanism in place, the absence of which was a source of concern to at least one director on each of the three boards. In terms of

individual performance, 36.6% of respondents reported that Chairs reviewed the performance of Non-Executives and 15.4% that Chairs and Non-Executives reviewed the performance of Executives. This was not confirmed in the case study authorities. Non-Executive director's performance was monitored very loosely, except when they were approaching the end of their term and were being considered for renewal. By contrast, Executive performance was formally and regularly reviewed but largely within the IPR framework - which restricted the involvement of directors other than the Chair. The advent of Audit and Remuneration Committee(s) is likely to increase both the monitoring of Executives and, paradoxically, the involvement of Non-Executive directors.

Few of those surveyed reported the existence of an explicit ethical framework (32.5%). Such a framework was also absent in all three case study sites. That said, all three Authorities observed the Code of Conduct (DOH, 1994) and their own Standing Orders/ Standing Financial Instructions - yet continued to experience conflicts of interest.

18.1.5 Accountability. Although the postal survey revealed that 87.9% of respondents reported that their Authority had an agreed statement of purpose and 77.2% reported that their Authority had explicitly defined its role, two of the three case study boards (Alpha and Beta) were in some

measure uncertain about their purpose/role. This seems to suggest that whilst directors understand the *raison d'etre* of the organisation they are much less clear about the role of the board and the nature of their contribution.

In terms of the relationship between the organisation/board and their various constituencies matters were equally uncertain. Survey respondents reported the existence of an explicit position in respect of the public (54.5%), the Authority's own employees (48.9%), providers (41.9%) and other NHS bodies (24.1%). In the case study authorities the public also enjoyed primacy. This, however, was evident from the assertions of directors and the existence of organisational values rather than from explicit policy statements *per se*. One important difference, however, was the greater predisposition of the case study boards towards other NHS bodies (and other agencies). It is likely that this is both a function of time i.e. the gap between the postal survey and the case studies, and, a necessary shift in the directorial mindset in response to fast moving events and continuing reform within the NHS. This largely inward looking and uncertain relationship with stake holders is, of course, mirrored in the ambiguous and unclear nature of accountability, at least in the view of the survey respondents and the case study directors.

Transparency fared equally badly. The postal survey findings suggest that the dominant pattern (83.7%) was for Authorities to meet publicly between 4-6 times per annum. Such an approach tended to be the pattern adopted in the case study Authorities also, with intervening private seminars. Whilst this does represent consistency it is still a lower degree of transparency than pre reform levels. In addition, the quality of the public meetings varied considerably between the truly open (Alpha) and the highly predigested and guarded (Omega). 76.5% of survey respondents reported the publication of an annual report and all the case study Authorities (eventually) published one also, the difference between the two being partly a function of time. A requirement to publish an annual report occurred between the postal survey and the case study visits.

18.1.6 Factors Influencing Performance Induction was reported by only 61.4% of survey respondents and was found to be almost completely absent in the case study sites; also, what provision did exist tended to favour Chairs and Chief Executives. Perhaps because of this a clear understanding on the part of directors of their statutory obligations and legal responsibilities is generally inadequate. Survey respondents reported limited understanding (59.4%) and the directors in the case study Authorities were equally unclear. It should be noted, however, that Chairs and CEOs consistently displayed higher

levels of understanding in both the survey and the case studies. These factors may explain, at least in part, the slow development of a corporate role amongst Executives. Whilst 63.3% of respondents to the postal survey described themselves as "generalists" this was the perception of only 23.5% of Executives. This picture tended to be reflected in the case study sites with Executives - the CEO (and generally) the Finance Director excepted - still growing into their new role and revised responsibilities. Personal influence upon performance was high. Indeed the postal survey revealed that most directors were influenced by either their Chair or CEO, which was also found in the case study boards.

Although some 91% of postal survey respondents reported very frequent/occasional informal contact, this was not found to be so in the case study boards - quite the reverse. The case study directors were almost at pains to point out that they did not meet socially/outwith the boardroom. It is likely that prudence proved a more powerful influence than the interpersonal benefits derived from informal contact. Interestingly, survey respondents reported a higher level of congeniality with 95.3% of them describing relationships as "close" or "cordial". Although relationships in the case study boards were satisfactory, significant tension was evident in all three and therefore they did not reflect the optimism of the survey. When the relationship between informal contact and the state of

director relationships from the survey data are cross tabulated a positive relationship can be seen - one significant at the 1% level. There is, therefore, a beneficial association between informal contact and healthy boardroom relationships.

18.2 A Cross Case Comparison

The section above compared the case study with the postal survey data. This section identifies the main similarities and differences between the case studies - thematically rather than as frequencies within a sampling logic and quantitative paradigm - see **Fig 18.1**

From **Fig 18.1** it is clear that all the case study boards shared a similar director profile, sound executive management but were poor at ensuring implementation. The case study boards were often weak in understanding the purpose and role of the board, the statutory obligations and legal responsibilities of directors, being clear about the nature of their relationship with and accountability to stakeholders, and, being sufficiently open and transparent.

Overall Beta was judged to be the most effective board in setting and working to a strategic vision and a clear (and informed) sense of direction. Alpha was the most aware of its public obligations and the need to both give an account and to be held to account. Omega had the strongest

Fig 18.1
Cross Case Analysis: Key Dimensions

Dimension of Corporate Governance	Case Alpha	Case Beta	Case Omega
Director Characteristics	✓	✓	✓
Direction	X	✓	X
Executive Management	✓	✓	✓
Supervision			
e.g. information	X	✓	X
e.g. implementation	X	X	X
Accountability			
e.g. purpose and role	X	X	✓
e.g. stakeholder statements	?	✓	X
e.g. transparency	✓	X	X
Factors Influencing Perf			
e.g. stat obligations and legal responsibility of directors	X	X	X

cast of Non-Executives and an experienced and effective Chair yet despite this - and perhaps the best understanding of the role and nature of the board - failed to deliver the promise. The reasons for these differences are complex and arise from the characteristics of the directors concerned and the context in which the particular board operated. That said, sound analysis, local knowledge and political wisdom were important factors in case study Beta. In contrast, Alpha operated rather more in the tradition of a

public Authority conscious of its stakeholders and the need to account for what was done in their name. In some respects Beta and Alpha were opposite sides of the same coin. The former concerned with defining and taking action, the latter with explaining and justifying what it did. Omega was something of an enigma in the sense that despite some admirable qualities it somehow failed to live up to expectation. This was the product of both a harsh and unforgiving local political environment and a strong 'commercial' orientation - perhaps at the expense of a solid understanding of the business. Given more time, however, it is likely that Omega would have continued to perform more effectively.

18.3 Conclusions

The overwhelming picture to emerge from the comparison of the postal survey and case study data is that the latter confirm the former in all but a few discrete areas. These areas of exception are:

a lower levels of continuity amongst Non-Executive directors

b a less clear cut distinction between the roles of Chair and Chief Executive

c directors less likely to challenge the Chair - especially in public

d evidence of decision making being more board than Executive centred

e board committees more evident

f the performance of Non-Executives being subject to review

g lower levels of induction available

h lower levels of informal contact between directors, and,

i lower levels of interpersonal congeniality.

A,b and c may suggest a concentration/centralization of power, d,e and f that the board as a whole is operating rather more effectively (in some dimensions) and g,h and i that knowledge and inter-personal contact remain immature.

Despite these points - some of which were a consequence of central direction - the case studies both validated the survey results and provided a contextual perspective on the reality of life in the boardroom. This diverse reality is perhaps most effectively revealed in the unique blend of strengths and weaknesses that each case study board displayed; a pattern borne out of the history of the Authority, the characteristics of the directors and the exigencies of the local circumstances.

- Chapter 19 -

Discussion

19.1 Introduction

This chapter will discuss - using Tricker's model of corporate governance (Tricker, 1984; Hilmer & Tricker, 1990) - the main findings from the research and begin to draw out the **practical and policy implications** from the study. In addition, **the need for further research** will also be identified where appropriate and some consideration of the **temporal influence** of events upon the findings will also be considered. The chapter provides an essential precursor to evaluating the significance and contribution of the research in the next and final chapter. It is important to reinforce the four key elements of Tricker's model - strategic direction, executive leadership, supervision and accountability - and to recall that the postal questionnaire (and the case study analysis) operationalise these terms in the light of the literature and the NHS context. In addition, the issue of board membership is important and has been combined with strategic direction; board and director development have also been added. It is convenient to approach the discussion of the findings under these five headings.

19.2 Board Membership and Strategic Direction

In terms of the **membership and structure** of District Health Authority boards both the pilot study and the main postal survey show that around a quarter of directors are women. Although this indicates a steady increase over previous levels (see e.g. Ashburner & Cairncross, 1991) they are, however, very much more likely to be a Chair or Non-Executive director than an Executive, especially a Chief Executive. This would suggest that the policy to increase female directors (NHSME, 1992) is successful in overall numerical terms but has had less impact in placing women in Executive director positions. In practical terms, however, female directors do appear to have some difficulties in making their impact felt e.g. placing items on the board's agenda and/or challenging the Chair. This may be a function of either higher turnover amongst Non-Executive directors generally, or, style differences between male and female directors. In the short term it places a particular responsibility upon Chairs to ensure that their female directors are given every opportunity to play a full and equal part and that female directors have access to director development programmes. In the longer term further research is needed to fully understand the differential contribution of male and female directors and barriers to progression.

The position of black and ethnic minority directors is even more stark. The number of such directors is low at

around 3.5% overall - a position comparable with e.g. Aanchawan (1995) who reports 4.7% Non-Executive directors - but there are marked variations between NHS regions. This pattern was also apparent in the case studies with only one black Non-Executive over the three Authorities and no black or ethnic minority members amongst the admittedly small number of the public attending public meetings of the boards concerned. This would suggest that the policy to increase the number of non-White directors (NHSE, 1993) has had very little impact to date. More needs to be done to open up the process of recruitment to the boards of NHS bodies and to encourage members of black and ethnic minority groups to become involved.

Within the context of NHS reform, considerable interest has been shown in whether the membership of the boards of NHS bodies demonstrate continuity or change. The findings from this research suggest the existence of both. Continuity in the sense that 39.1% of Chairs have been in post for more than 5 years and 56.6% of Non-Executive directors for between 2-5 years; but change to the extent that almost a third of Non-Executives have been appointed in the previous two years - a pattern reflected in the case study Authorities. If the policy objective was to create substantial change then reform, as reflected in the membership of District Health Authority boards, would suggest that this has not taken place. If, however, the objective was change of an incremental and cautious nature

- as seems more plausible - then it has succeeded.

The notion of continuity cannot, however, be applied to Executives in quite the same way. Whilst many held senior positions (often within the same Authority) all are now *Executive* directors and thus full members of the board. Curiously, however, a number of boards covered by the main postal survey and all of the case study boards were below their maximum possible strength in terms of director numbers. The reasons for this were unclear but in many cases the full complement of five Executives had not been appointed and in other cases (including all the case study boards) there were Non-Executive vacancies. In so far as the policy (S.I. 1331, 1990) makes provision for an eleven strong board composed of a Chair, five Non-Executive and "up to" five Executive directors, the existence of a significant number of 'under strength' boards represents a failure of sorts. The reasons may be associated with deliberate attempts to outnumber Executives and thus maintain some semblance of earlier and unequal relations between 'members' and 'officers', or, the deliberate creation of board vacancies for political advantage on the occasion of further merger between District Health Authorities and Family Health Service Authorities in the Spring of 1996. This suggests a conscious departure at both local and regional level from the stated policy. However, whatever the precise reasons, in the short term such distortions will reduce the diversity available to such

boards and concentrate power in fewer hands. Neither is desirable. These issues require further research to identify the extent to which this is widespread and why, precisely, it occurs and what effects smaller/imbalanced boards have upon the exercise of corporate governance.

The background of 69.6% of Chairs and 45.9% of Non-Executives derives from the private sector. In political terms this is consistent with the desire to create boards based on a private sector model. There are, however, some dangers if the culture of District Health Authority boards moves too rapidly from a public to a private sector orientation. Something of this was seen in case study Omega where culture and style were rather more private than public sector in orientation, and, in some measure, may explain its inward looking orientation and business mindset. In terms of future research, the presumption that the performance of directors from the private sector is superior to those from other backgrounds needs to be tested.

Turning now to the issue of **strategic direction** there were three issues to emerge which gave rise to particular concern i.e. accountability, issues of strategic importance and the role of the Non-Executive. In terms of accountability, only 61.8% of respondents to the main postal survey reported that their Authority's mission statement indicated to whom and for what the Authority

would be held to account, a situation mirrored in all three case studies. At a strategic level most boards were clear about purpose - which vindicates the rationale of the *Working for Patients* reforms - but were much less certain about accountability, even against the backdrop of the advice subsequently set out in the Code of Accountability (DOH, 1994). In the way that health care providers see themselves as 'accounting to' their purchasers rather than to the public, so District Health Authorities appear to see themselves accountable to Government via the RHA/NHS Executive. In short, accountability appears to be determined by the provision of revenue rather than any wider sense of social responsibility. This is consistent with the notion of Government as the guardian of tax revenue rather than the champion of local democracy. Further research is therefore needed to investigate the extent and the means by which District Health Authorities seek to involve local communities in setting strategic direction. Such research should also be concerned with understanding which measures create and sustain a consequential obligation to account to such communities in respect of both the strategy pursued by a District Health Authority *and* the resources consumed in its implementation.

The second key issue is the nature and orientation of the strategic agenda. A little more than a third (36.4%) of respondents to the survey reported that purchasing was the most important strategic issue. This was followed by

matters of finance (20.9%); something clearly important in all three case study settings. The former is consistent with the policy embodied in the *Working for Patients* reforms; the latter with events, the reconfiguration of Acute services, and, with further NHS reform.

Clarity of strategic focus was not, however, matched by a concomitant involvement by directors who, in the main postal survey, reported that only 51.4% of boards set priorities for member involvement. In terms of the case studies, involvement tended to veer towards the functional rather than strategic. Those directors who were least certain about member involvement tended to be Executive and Non-Executive directors;they were also the least certain about the distinction between the Chair and the CEO, or, to believe that they could effectively challenge the Chair. From a policy point of view, whilst new boards have been created, the involvement and effectiveness of some directors is less than complete. This suggests the need for improved selection and systematic development. In common with corporate governance in the private sector further research concerning the role and contribution of the Non-Executive director is needed; indeed this is said to be a major concern of the Hempel Committee i.e. 'Cadbury II'. Despite such deliberations and indeed the growing debate about corporate governance more generally it is clear that a number of directors are concerned about the style and pattern of working in their own board. In practical terms,

periodic review of working style would help isolate real or perceived problems and act as a focus for debate concerning board performance. An adapted version of *Good Practice for Directors* (IOD, 1995) - *Criteria for NHS Boards* (IOD, 1996) - should provide a helpful focus for such activities.

19.3 Executive Leadership

In terms of executive leadership some of the survey issues e.g. concerning access to the agenda and the distinction between the role of the Chair and the Chief Executive, are common to the analysis of both strategic direction and executive leadership. Each of these has been explored in earlier chapters and discussed above. This section will, therefore, focus upon the remaining elements. i.e. the style and balance of decision making and the nature of director contribution.

The pattern of decision making was predominantly consensual across both the postal survey and the case studies. Such an approach is rather more in keeping with the earlier consensus approach in the NHS than the 'strong man'/general management system which replaced it and immediately predated the present management arrangements. Some directors, particularly women and those more recently appointed, reported a higher incidence of voting. This may suggest a move towards more explicit forms of decision taking or the pessimism of some (mainly female) directors

concerning their ability to influence decisions in more subtle ways. Overall, however, decision making appears rather more focused, business like and less distorted than in the system it replaced. This would suggest that the policy basis of reform has been successful. In practical terms, however, it will be important for Chairs to ensure that the less vocal, the less confident and the newly appointed have the opportunity to participate by means other than by a show of hands.

The manner in which decisions are taken is, in part at least, a function of the contribution that directors make. Although two thirds of survey respondents reported that they played a "generalist" role, others tended towards a more specialist role; a pattern also found in the case study boards. In this specialist group were some Executives (particularly Directors of Finance and Directors of Public Health) and some Non-Executive directors. The reasons for this are complex. The "specialist" Executives - about a third of survey respondents - have yet to be fully developed and to mature into their corporate role and responsibilities; some Non-Executives have argued the need to 'distance' themselves from management in order to preserve their independence, others are more comfortable with more concrete tasks.In practical terms this suggests boards need to regularly discuss the manner of their working - perhaps through 'away days' - encourage *all* directors to play a corporate role, and support such

measures by overt development where appropriate. To do otherwise would be to significantly undermine the concept of a unitary board - for how could this be sustained with almost all Chairs and CEOs adopting one perspective and a sizeable proportion of the remainder operating in a substantially different manner ?

Finally, when asked who made most decisions, important differences emerged, over time, between the views of the survey respondents and those of the case study directors. The pilot study found that most decisions were taken by executives (91.8%), a situation mirrored almost exactly in the main postal survey (92.0%). When the case study findings are considered, however, a much higher proportion of decisions were taken by the board, indeed certain decisions, e.g. concerning strategy, were reserved exclusively for the board. Whilst this represents desirable progress, as noted above, some directors have difficulty with their corporate role and therefore, in practice, such decisions may fall to less than the whole board. One has to assume that this is by accident, a function of growing experience, but, if it was by design, it would perhaps explain some of the misgivings about the Chair/CEO axis and the apparent inability of some directors to make their presence felt.

We can conclude that decision making is more focused, business like, consensual and more corporate than in the past - to that extent - the policy embodied in the *Working for Patients* reforms has generally been successful. Qualification of this view, however, is necessary in regard to the expression of difference *within* boards which may be somewhat constrained by the propensity of some Executives to enact a specialist rather than corporate role. Both are susceptible to good chairmanship and the need for on-going development and discussion. In terms of development, boards need to access appropriate training for Executives and Non-Executives together, or, action research/learning set strategies which involve the entire boards. Development at this level is not simply the provision of knowledge but the pursuit of shared insights which shape collective behaviour.

19.4 Supervision

An important indicator of the attitude of District Health Authorities to supervision was signalled in their views of and position on the role of the Company Secretary, or, as it is known throughout the NHS, the Secretary to the Board. Despite the rejection of such a role by the Corporate Governance Task Force (Shaw *et.al.*, 1993), a little less than half the respondents to the postal survey (40.8%) indicated that discussion had taken place in their Authority with a view to making such an appointment.

Amongst the case study boards, Omega had made such an appointment, Beta intended to do so (and indeed did do so following the second case study visit) and Alpha rejected the idea out of hand. Such enthusiasm runs counter to expressed policy (ibid) but is consistent with a felt need to reduce the exposure of boards and their directors.

This has been successful in the sense that a named individual has a responsibility to take an overview of board functioning and thus promote 'good practice'. It is less successful in the sense that such roles are frequently combined with other duties - which thus dilutes the benefits to be derived from such appointments - and, the posts are often of lower middle order grading which results in the Secretary to the Board having considerably less power than those s/he influences. Perhaps the greatest weakness, however, lies in the design of the role which seems to be more concerned with reducing corporate vulnerability than with actively promoting sound governance and, in particular, with ensuring that decisions taken by the board are implemented. More research is needed, therefore, to explore the nature and effectiveness of such roles which would also stimulate both wider debate and improve role design. Further training courses are needed for the incumbents and a consideration of the role, duties and powers of the Secretary to the Board should be an essential component of all director development programmes.

Board committees grew in strength as the programme of research unfolded. Least evidence of their existence was evident from the pilot study, audit (55.7%) and other committees were reported in the postal survey and all the case study Authorities had by, or shortly after, at least an audit and a remuneration committee. Committees appeared to work well, most had a clearly understood mandate and were thus successful in policy terms. Both boards and committees, however, are heavily dependent upon appropriate and sound information if they are to discharge their responsibilities. Most directors in the survey (80%) were reasonably happy with the quality and quantity of information they received. Although this was generally true of the case study boards, financial information was seen as the most sound whereas contract, activity and quality information was much poorer. This reinforces the need for practical measures to improve the quantity, quality, presentation and interpretation of data. This is one area that does not require further research.

The emergence of the Secretary to the Board role, the growth of board committees and a general level of satisfaction with information can all be taken as portents of effective supervision. The picture changes markedly, however, when attention is turned to the measures taken by boards to review the implementation of collective decisions and the individual performance of directors. A little more than half of survey respondents (56.3%) indicated the

existence of a mechanism by which directors could ensure the implementation of board decisions. The situation in the case study Authorities was even worse with none of the boards concerned having an explicit mechanism - which was a cause of concern to some of the directors involved. Given that the case study Authorities were not atypical or especially poor performers, this may suggest an optimistic view on the part of survey respondents. Further research is therefore required to establish the reasons for the marked discontinuity between setting direction and taking high level decisions, and, ensuring that these activities result in action. The bias in supervision appears to be towards ensuring that the executive does not behave improperly rather than ensuring that it acts properly. To the extent that central guidance has tended to adopt such a bias itself, the policy could be said to be successful. Such a narrow interpretation, however, is not consistent with a more rounded approach to effective governance. In the sense, therefore, that thinking and practice fall far short of such an ideal, the present situation *is* unsatisfactory.

Turning now to the supervision of individual directors, responses to the postal survey suggested that the performance of Non-Executives was twice as likely to be reviewed (36.6%) as that of the Executives (15.4%). This was counter intuitive and somewhat at odds with the findings from the case study boards, where the reverse was true. These differences cannot easily be explained but the

picture in the case study boards is thought to be the more 'representative'. The picture, however, suggests that either practice leaves much to be desired or the review of individual performance is much lower and less frequent than expected. It follows that if the logic of reform was to create boards based on the private sector model - who *do* exercise supervisory responsibilities - the findings from this research suggest that this has *not* been successful. This implies a need for further direction, improved training and the dissemination of good practice guidance. Further research should therefore focus upon why boards appear to be less effective here than elsewhere and upon the development and implementation of information and behaviourial systems to address this deficit.

Finally in this section we consider the ethical dimension of corporate governance. Survey respondents clearly indicated a unequivocal commitment to ethical practice (98.8%). This, however, was not matched by the existence of an ethical code (32.5%) and a third (33.9%) reported conflicts of interest. The position in the case study Authorities was not materially different. In practical terms, therefore, there was some contradiction between aspiration and expression. Although the main postal survey preceded the publication of the Code(s) of Conduct and Accountability (DOH, 1994), the case study work followed them, but they did not substantially reduce the gap between the rhetoric and the reality. Directors, at the

level of principle, supported the need for the proper conduct of public business, but, with few exceptions, were unable to demonstrate a value framework to guide and test behaviour at a local level. This, again, is a serious weakness and the cause of continuing conflicts of interest and suspect behaviour (National Audit Office, 1996; Butler, 1996). The Nolan Committee's findings, in part, addressed such issues but it is too early to make any assessment of their impact.

19.5 Accountability

Turning now to the issue of accountability, although respondents reported that District Health Authority boards had discussed both their purpose (87.9%) and role (77.2%), the existence of a strong sense of corporate identity was much less common (18.6%). This pattern was reflected in two of the three case study Authorities (Alpha and Beta) in both of which there were uncertainties, particularly concerning the differing roles played by directors, and, in two of the three case studies (Beta and Omega), some ambivalence towards openness and ambiguity concerning accountability obligations. The survey data shows a similar ambiguity in terms of the prevalence of mission statements (84.6%) but markedly lower levels of agreement (61.6%) when respondents were asked if such documents "state to whom and for what the Authority will be held accountable". Such findings suggest that the historical pattern of a poor

understanding of and orientation towards public accountability remains, despite the *Working for Patients* reforms. Further research is therefore needed to understand and overcome this fundamental sense of reticence.

In rather more practical terms, survey respondents were asked if their Authority had an explicit statement concerning stakeholders. In order of magnitude statements were believed to exist in terms of the public (54.5%), the DHA's own employees (48.7%), its providers (41.9%) and other NHS bodies (24.1%). Not only are these low levels in themselves but analysis by director reveals that some 1:3 Chairs and about half of Non-Executive directors did not know if their Authority/board had such statements. In terms of the case study Authorities the public also enjoyed primacy, but in an instinctive rather than an explicit manner. By contrast, relations with other NHS bodies were much more important, evident and somewhat more explicit (e.g. Beta). The existence of an explicit position concerning key stakeholders - an article of faith in the private sector - is, curiously, largely absent from the world of the District Health Authority. This is not an implementation failure but rather a policy deficit, in the sense that the case for such an analysis and strategy has not yet been made. The growing interest of the Labour opposition in the idea of "stakeholder capitalism" (Hutton,1996), however, suggests this may change.

Public meetings are an important means of accounting to the public - both in terms of conducting business in public and, to some extent, answering to the public for decisions taken and money spent. Although the pilot study findings suggested a significant decline in the number of public meetings, the main survey suggested some degree of recovery with about half (52.7%) meeting between 4-6 times per annum and about a third (36.4%) meeting between 10-12 times per annum. The former is consistent with a pattern of public meetings alternating with member seminars, which was the pattern found in all three case studies. The latter reflects the pre-reform pattern of public meetings and at 36.4% represent a substantial reduction in transparency. Although the *Working for Patients* reforms made little reference to the pattern or nature of public meetings, some distaste with (unnecessary) consultation and the then requirement for Trusts to have only one board meeting in public (DOH, 1993 p6) may have signalled some indifference towards such matters. In the wake of a number of scandals, however, the boards of NHS bodies were subsequently exhorted to become rather more "responsive to the community" (Audit Commission, 1995) and open (NHSE, 1995a).

As well as questions about the frequency of public meetings there are also important considerations as to the quality of the proceedings for those who do attend. The case studies revealed some wide variations in the perceived quality of experience for the participating members of the

public. Case study Alpha was very open and conscious of its relationships with its public, unlike case study Omega who was very guarded and somewhat dismissive of the value of public meetings. In part such differences reflect different styles and priorities but - perhaps in greater measure - fundamental uncertainties about accountability obligations together with anxieties about media interest and press coverage.

From a policy viewpoint the frequency, quality and nature of public meetings remains problematic, at least in terms of expressing accountability. In part this may be a function of the previous and somewhat ambiguous position of Government but more probably a product of declining enthusiasm by District Health Authorities. In practical terms Government may wish to consider setting minimum requirements via the corporate contract[1] agreed with District Health Authorities each year. Further 'good practice' guidance might also be helpful as would further research to identify the critical factors which encourage the public to attend, and the best means of their participation in, District Health Authority/board meetings in public.

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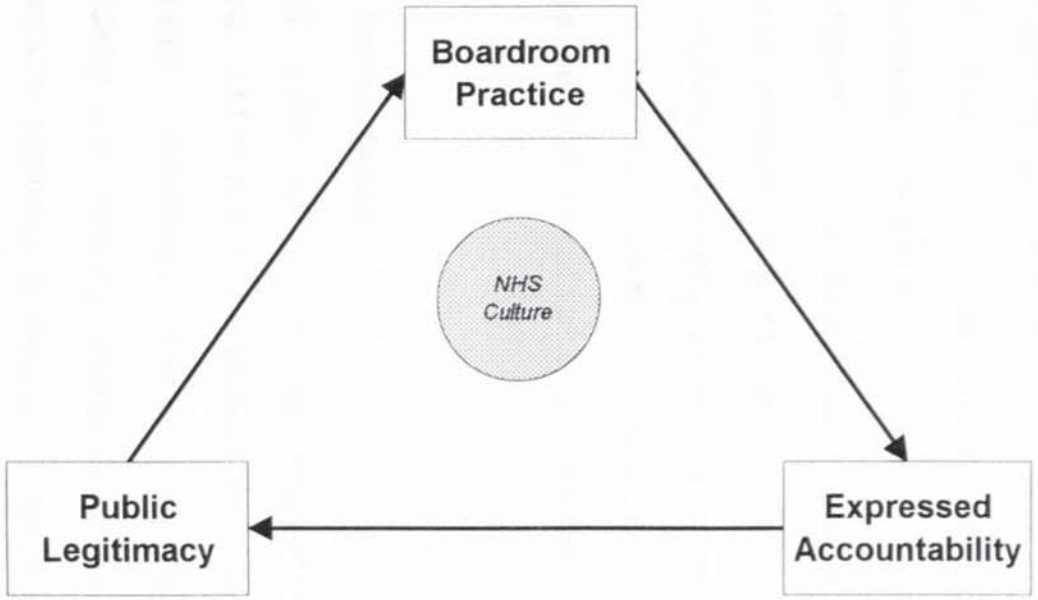
[1] The corporate contract is the explicit device by which the Regional Office of the NHS Executive agrees with DHAs - in writing - the performance required of them and thus the criteria against which their effectiveness will be judged.

The publication of an annual report is now a widespread practice. This was a clear finding from the results of the postal survey (76.5%) and also the case in all three case study Authorities. Whilst the majority of annual reports are produced to a very high standard and 'give an account' they are no substitute for an appropriate and well organised meeting in public at which boards can, in part, be 'held to account'.

The issue of accountability, perhaps more than any other dimension of corporate governance, raises concerns in the minds of both commentators and the public alike (Jenkins, 1995). In the normal course of events one would expect to see a circular relationship between the legitimacy of boards and boards at work; between boards at work and the expression of accountability; and between the expression of accountability and the climate of the board's legitimacy - see **Fig 19.1**

The problems associated with accountability in the NHS appear to be threefold. Firstly there is poor recognition of stakeholder interests and a consequent failure to appreciate or meet their needs. Using the technique of gap analysis (Johnson & Scholes, 1990 p224) this results in a weakened link or gap between boardroom practice and the need to express accountability. Secondly, when such apparent indifference is combined with, for example, infrequent or poorly run meetings, this can be said to

Fig 19.1
Sound Accountability in District Health Authorities

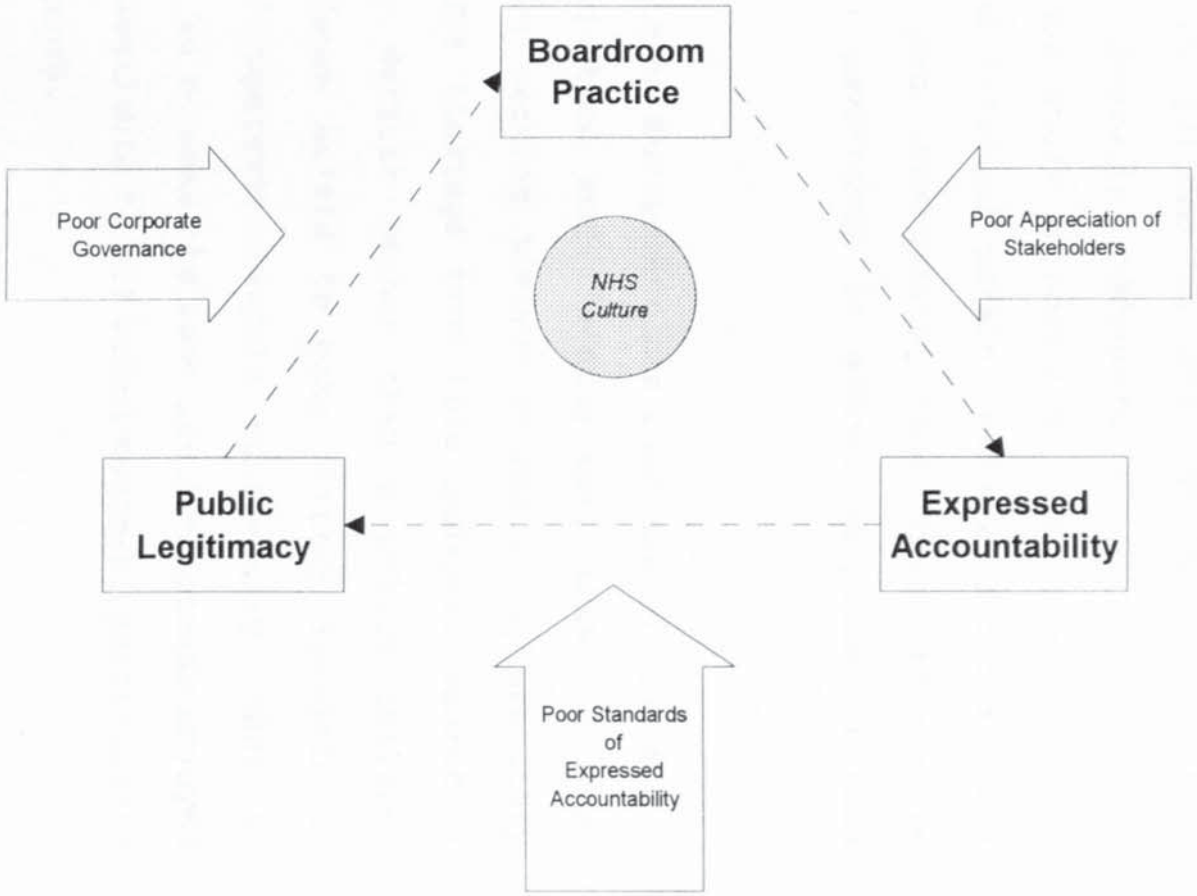


result in poor standards of expressed accountability. This again weakens a link, this time between the need for expressed accountability and the climate of public legitimacy necessary for District Health Authority boards to function effectively. Finally - and in addition to these essentially 'local' factors - continuing governance difficulties sustain the belief in suspect standards of NHS corporate governance. This seriously undermines confidence and creates a gap between legitimacy and boardroom practice. This negative dynamic - see **Fig 19.2** - has driven boards into an increasingly defensive posture which is ever more inward rather than outward looking. It would seem that a new paradigm for public service needs to take root and/ or, new democratic processes and institutions are needed.

19.6 Board and Director Development

A critical learning opportunity is the exposure to information and culture afforded by induction and/or orientation. Unfortunately, however, this is not an opportunity that is widely or evenly available to the directors of District Health Authority boards. The survey findings indicate high levels of access to such training for Chairs/CEOs (80.9%) but much lower levels for Executive/Non-Executive directors (50.7%). Indeed almost a third of all Executives (35.1%)) indicated that they had received no induction training at all. This has important consequences for senior managers if they are to make a

Fig 19.2
Poor Accountability in District Health Authorities



successful transition to Executive director. When the overall position was compared with the case study Authorities the situation was, if anything, worse, with access to induction being all but absent. The significance of this becomes apparent when only 59.4% of survey respondents reported being given "information concerning their statutory obligations and legal responsibilities". A comparable and generally inadequate situation was also found in the case study Authorities. Little wonder that difficulties and tensions persist between directors and that confusion and uncertainty about their respective contribution to governance is almost palpable in some Authorities.

In policy terms Government has continually stated its support for induction and training but, thus far, has stopped short of setting minimum standards or statutory requirements. The findings from this research therefore shows a policy deficit rather than a policy failure. Sufficient evidence exists to make further research on areas of need/competence largely unnecessary. What is needed, rather, is to make the same level of access enjoyed by Chairs/CEOs available to all board members, particularly Executive directors.

Increasing understanding, developing expertise and building relationships can also derive from the interpersonal influence directors exert upon one another

and from social contact. The survey findings clearly support the existence of the former, but with some important differences in salience. Interestingly both Non-Executives and Executives are the least influential of all directors. This may betray important skill and experience differences, or, simply reflect power differentials (see Pettigrew & McNulty, 1995, for discussion of boardroom power). When influence is probed further, the survey showed frequent (46.4%) or occasional (53.4%) social contact between directors, but almost a complete lack of such contact within the case study boards. There is no obvious explanation for this but it may be associated with particular sensitivities throughout the Region given previous governance difficulties at the RHA itself.

In practical terms the survey findings demonstrate a clear relationship between social contact and perceptions of positive boardroom relations. Aside from the statistical strength of the relationship, the experience of the case study boards inversely corroborates the position. None of the case study boards had taken specific steps to encourage social contact but did - in all three cases - experience significant tensions between elements within the board(s). Whilst matters as ethereal as influence and social contact are beyond the scope of policy making the evidence would suggest there is value in such activities and should, therefore, be judiciously encouraged under the rubric of 'good practice'.

19.7 The Temporal Dimensions of Corporate Governance Research

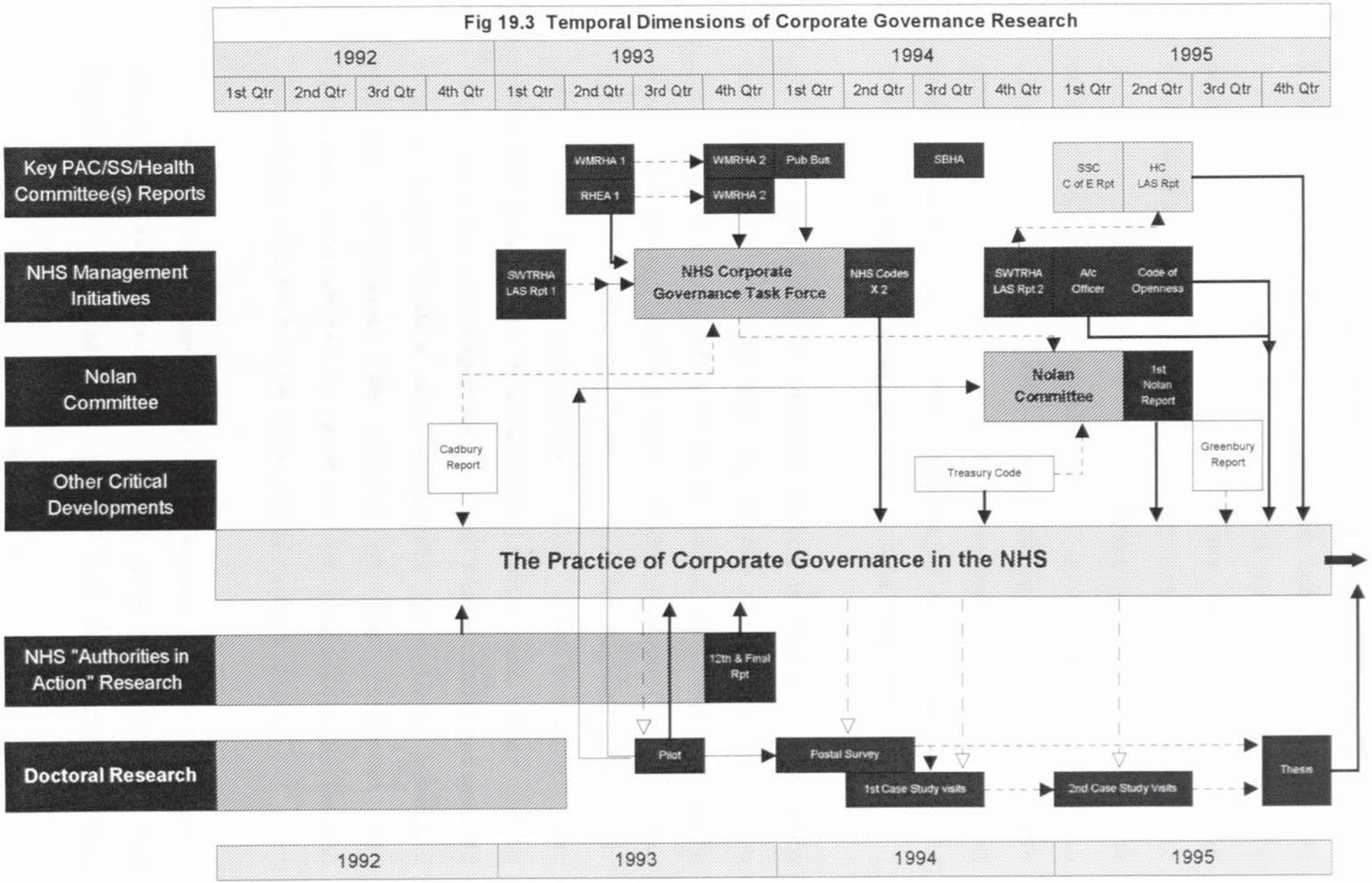
The study of corporate governance in the NHS revealed:

* a complex inter-relationship between events, policy and practice;
* between the practice of corporate governance in both the private and public sector (and the climate of public opinion); and,
* between both of these clusters and the progress of corporate governance research both generally and more specifically - see **Fig 19.3**

Thus far this chapter has discussed the findings in terms of their practical and policy implications, and, the extent to which they generate further/future areas of research. We now turn to a consideration of the train of events overall and, in particular, their impact upon progress and their influence - or not - upon specific findings.

Prior to the publication of the Cadbury Report (Cadbury, 1992)) in late 1992 the term corporate governance was one almost completely absent from the lexicon of the NHS. For despite the introduction of the *Working for Patients* reforms on the 1st April 1991 - which included the adoption of private sector style boards by District Health Authorities - there was little real awareness of either the term or its significance other than by means of the *Authorities in Action* research programme. This, however, changed dramatically with the publication of the Cadbury Report which introduced the term corporate governance to a

Fig 19.3 Temporal Dimensions of Corporate Governance Research



wider and increasingly uneasy public. Cadbury proved to be a beacon which not only informed but indirectly illuminated areas of ill understood, seldom glimpsed and often poor practice. There followed a litany of PAC and other Parliamentary reports which raised serious questions about standards of NHS corporate governance specifically and the conduct of public business more generally. These twin pressures produced first the Corporate Governance Task Force who, ultimately, published the Code(s) of Conduct and Accountability (DOH, 1994) and later the Nolan Committee who published *Standards in Public Life* (Cm 1523, 1995).

This was a highly fertile period in terms of corporate governance in the NHS and, as events were to prove, also for attempts to research it to evaluate progress. The pilot study and postal survey were conducted post Cadbury but prior to the Codes of Conduct and Accountability (DOH, 1994). The first case study visits were conducted post Codes but pre Nolan, whereas the second case study visits were (in part) contemporaneous with Nolan. This pattern of events helped ensure that corporate governance remained topical throughout the period of the fieldwork and doubtless contributed to good survey responses and helped facilitate access to the case study Authorities.

The general assumptions in respect of the findings - where they were 'good' or improved over the period of the fieldwork - was that the policy had been successfully

implemented and/or that directors had learned and developed in the light of experience. Examples include the stability of directors' views concerning clarity of organisational purpose in respect of District Health Authorities and the consequential strategic primacy of commissioning, both of which are suggestive of the successful implementation of the *Working for Patients* reforms. Some progress was, however, due to intervening factors. The improvement in the position and strategic importance of Finance between the pilot study and the main survey, for example, suggests perhaps the influence of the PAC report *The Proper Conduct of Public Business* (PAC, 1994b) upon director mindset and practice. A similar influence can be argued in terms of the increased prevalence of board committees between the pilot study and the subsequent main survey - the influence on this occasion being the Code(s) of Conduct and Accountability (DOH, 1994). Another example is the increase in the reported frequency of board meetings held in public between the pilot study and the postal survey/case studies. The critical influences here being the debate about transparency generally - as a consequence of the Code(s) of Conduct and Accountability (DOH, 1994) and the Nolan Report (Cm 1523, 1995) - and also the publication of the Code on Openness (NHSE, 1995). Finally, the adoption of the Secretary to the Board role is an important example of NHS corporate governance evolving in the light of the wider debate and best practice in the *private* sector rather than in the face of public policy. The existence of such

influences demonstrate that NHS corporate governance is dynamic and therefore continually evolving, and thus reinforces the difficulties of assessing progress at single point in time.

Alternatively where findings were 'poor' or failed to improve over the period of the fieldwork the assumption has to be that the policy had not been implemented, if implemented was unsuccessful and/or that directors were unable to learn from experience. Clear examples here include the ambiguity which surrounded accountability. Although District Health Authority directors were clear about purpose they were unclear about accountability and its proper expression. Despite reform - which in part at least sought to strengthen the link between a District Health Authority and its immediate community - accountability is still largely expressed via the institutional hierarchy i.e. to the Regional Office of the NHS Executive and also, rather inadequately, via a reduced number of public meetings. Not only do both these elements reveal continuity with the past and therefore something of a policy failure, they have also been remarkably resistant to subsequent attempts to reverse them. Despite the exhortations of the Code(s) of Conduct and Accountability (DOH, 1994), the Nolan Committee (Cm 1523, 1995) and the Code on Openness (NHSE, 1995) the situation - as late as the second case study visits in early/mid 1995 - remained unaltered. Another example of an element of corporate

governance practice which has (astonishingly) remained resistant to both policy initiatives and events was the reluctance of directors to take appropriate steps to ensure that decisions they have taken have been properly implemented. This reluctance has resisted the move from public authority to corporate board, remained impervious to the 'case law' of the PAC reports, the Code(s) of Conduct and Accountability (DOH, 1994) and continuing evidence of poor implementation. A measured response to this single issue would substantially improve the performance of the boards of all NHS bodies.

9.8 Conclusions

This chapter has discussed the findings from the research in terms of their practical and policy implications, and, the extent to which they generate further/future areas of research. Latterly it has addressed the overall train of events and, in particular, their impact upon progress and their influence - or not - upon specific findings. The next and final chapter will seek to draw together the strands which emerged from the research in order to reach a conclusion.

- Chapter 20 -

Conclusions

20.1 Introduction

This chapter draws together the disparate strands as a final conclusion to the research. The chapter will open by reflecting upon the research strategy/methods employed given the importance of selecting approaches appropriate to the nature of the research questions and the influence of the organisational and individual characteristics of those under study. Next, the principal findings will be identified; most particularly in relation to the series of research questions posed at the outset. The strategy/methods and the principal findings will, together, subsequently provide the basis for a determination of the strengths and limitations of the research.

The chapter will next seek to assess the contribution of the research to the NHS/public sector literature and to the corporate governance literature. Such an appreciation, inevitably, leading to the identification and prioritisation of further/future research in the field. The chapter will conclude by reflecting upon the prospects for corporate governance in the future.

20.2 Methodology and Methods

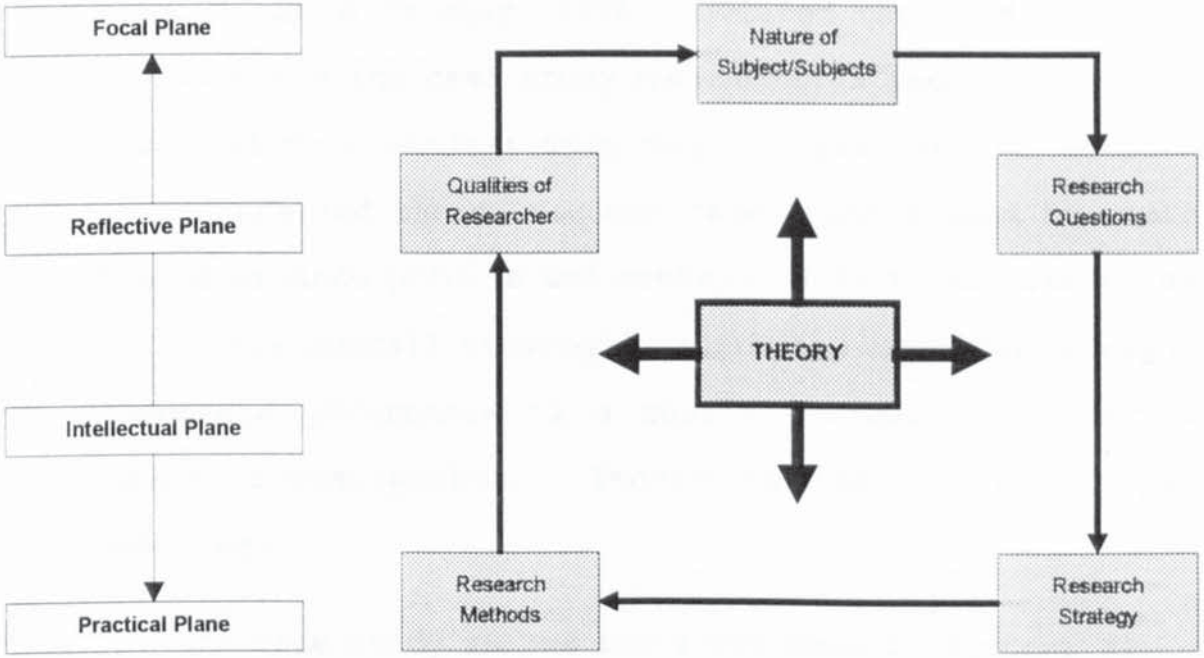
Whilst both methodology (Chapter 7) and methods (Chapter 8) have been considered in some detail it is appropriate to reflect upon some of the critical inter-relationships (see **Fig 20.1**). The nature of the subject and of the subjects themselves make the study of corporate governance particularly problematic, for it is a topic that few people - at least until comparatively recently - had even heard of and the practice of which seldom saw the light of (public) day. Directors too are generally very private people who carry out their duties under conditions of near secrecy. Such characteristics make research in this field problematic but not impossible. Initially one has to have sufficient knowledge and awareness to formulate appropriate research questions (see 20.4 below) which, in turn, begin to shape the address and the overall research strategy.

Leaving aside the specific research questions for the moment, in broad terms, the nature of the investigation was concerned with:

* establishing the existence and quantifying aspects of corporate governance in English District Health Authorities, and,
* seeking to understand some of the processes at work and the impact upon these of context/ contextual variations.

The former lent itself to the quantitative paradigm and the survey method, the latter to the qualitative paradigm and the case study method. Each paradigm and method was

Fig 20.1
Research Design - Critical Relationships



therefore chosen to suit the combination of the *nature* of the investigation and the *specific* research questions being addressed. Also important was the sequencing of these. Typically the case study method is used to gather data and impressions as a means of formulating theory prior to undertaking a survey. On this occasion the sequence was reversed. The experience of the author and, more particularly, the adoption of Tricker's constructs (1984; also Hilmer & Tricker, 1990) obviated the need for theory building via the case study method. As a result, the survey was used to quantitatively map the practice of corporate governance and the subsequent case studies used to explore the governance process and context. Whilst the methods used within the overall strategy contributed important insights, corporate governance is a subtle process which requires subtle investigation. Indeed as Hartley (1994, p212) observes:

> "A case study allows for a processual, contextual and generally longitudinal analysis of the various actions and meanings which take place and which are constructed within organizations. The open-ended nature of much data-gathering also allows for processes to be examined in considerable depth. This contrasts with survey methodology where although associations may be found between variables it is harder to tease out what processes lie behind the correlations."

Experience from this study supports such a view and suggest that the case study method is rather better adapted to investigating complex processes at the centre of rather than distanced from their contexts, and, for identifying,

probing and understanding the nuances of the behaviourial repertoires found in the boardroom.

Finally, no study can be separated from the characteristics and qualities of the investigator. This was especially true of this research - particularly the case studies - which required the author to be both expert and novice. Expert in the sense of demonstrating wisdom, sound research practice and political sensitivity; novice in the sense of still being able to ask the 'naive' question. The notion therefore that qualitative methods offer a 'softer' option in methodological and personal terms is simply not the case. Indeed one can readily concur with Yin (1989, p62) when he notes that "the demands of a case study on a person's intellect, ego and emotion are far greater than those of any other research strategy".

This section of the chapter has sought to draw out and underline some **important conclusions** in regard to methodology/methods. In particular:

* the nature of the subject/subjects imposed a number of constraints in prosecuting research of this type
* such constraints had to be understood given their influence upon the research strategy and the selection of appropriate and acceptable methods
* that the case study method was particularly well suited to research of this type and of value as a primary rather than secondary source of data, and,
* that the researcher is not an inert component in the process but critical to the dynamic.

20.3 Principal Findings

The principal findings from this research - already reported in full in Chapters 10-17 - are summarised in **Fig 20.2** below and set out in a manner consistent with Tricker's model of corporate governance (1984; also Hilmer & Tricker, 1990). It is important, however, to look beyond individual findings towards their collective meaning. In these terms the findings can be thought of as concerned with two main clusters: the exercise of power and the setting of direction, and, with boards getting it right and accounting for performance.

20.3.1 The Exercise of Power and the Setting of Direction.

The findings from this research suggest the existence of a worrying combination of factors which at best make some boards vulnerable and at worst open to unacceptable governance risks. The higher than expected prevalence of 'under strength' boards means, inevitably, that power is concentrated in much fewer hands. Although in itself not necessarily a problem, the risks associated with this situation increase perceptibly where the Chair/CEO axis is strong, where Non-Executive directors lack a clear focus and play a peripheral role in strategy formulation, and, where Executives continue to play out a specialist and/or senior managerial rather than corporate role. This combination can result in an imbalanced board where the Chair/CEO play an increasingly dominant and unchecked part in events. The remaining bulwark - at least in some

Fig 20.2
Principal Research Findings

On the basis of the perceptions of directors and as a result of observing boards in action...

1. Board Membership

* the number of female directors has substantially increased, but not amongst Executives and some doubts remain concerning their impact

* the number of black and ethnic minority directors remains low

* the membership of DHA boards demonstrates rather more continuity than change

* a significant number of DHAs are below strength i.e. below their maximum possible numbers

* the majority of DHA Chairs and half of NEDs come from a private sector background.

2. Strategic Direction

* directors are clear about organizational purpose but much less clear about accountability

* directors see accountability in inward looking terms which has consequences for non NHS stakeholders

* the strategic focus of DHAs is predominantly concerned with commissioning and finance

* NEDs play a variable but largely peripheral part in strategy formulation

* DHAs infrequently review the manner and style of their working.

Fig 20.2 (cntd.)
Principal Research Findings

3. Executive Leadership

* directors have access to agenda setting but NEDs mostly fail to avail themselves of the opportunity
* there is clarity between the roles of Chair and CEO
* the Chair/CEO axis, however, often marginalise NEDs
* decision making is predominantly consensual
* the contribution of NEDs is undermined by having little clear focus or priorities
* executive directors are still, predominantly, senior managers rather than corporate actors
* the majority of key decisions are now made by the board rather than by the executives.

4. Supervision

* many DHAs value and have appointed a 'Secretary to the Board'
* the majority of DHAs have established audit and remuneration committees which have clear mandate(s)
* financial information to boards is generally good; contract and quality information is poorer
* the majority of DHA boards demonstrate poor scrutiny of policy implementation and executive performance
* commitment to ethical practice is high but local ethical statements/codes are rare
* conflicts of interest remain and are not uncommon.

Fig 20.2 (contd.)
Principal Research Findings

5. Accountability

* many DHAs have a poor sense of corporate identity

* boards are uncertain about the focus and nature of their accountability responsibilities

* few boards have an explicit statement concerning and their orientation towards stakeholders

* the frequency of public meetings of DHA boards is significantly less than pre reform levels

* the majority of DHAs publish an annual report.

Board & Director Development

* exposure to induction is poor for all but Chairs

* the CEO is the most influential role model for directors

* the majority of directors - Chairs excepted - are unclear about their statutory obligations and legal responsibilities

* contact between board members is predominantly confined to meetings of the board

* relationships amongst directors are predominantly close and cordial.

District Health Authorities - is the Secretary to the Board, who, as noted earlier, is not infrequently a middle ranking subordinate who reports to the Chief Executive and accounts to the Chair.

This is not to suggest that strong and ambitious Chairs/CEOs actively seek to marginalise their boardroom colleagues (although some do), but rather that uncertainties about the Non-Executive role and inexperience on the part of many Executives may require Chairs/CEOs to fill a void. This may lead an Authority to pursue an idiosyncratic course based upon strong personal or political views, or, to committing itself to major capital or other projects on the basis of a narrow or ritual debate. Neither is this to suggest that Chairs/CEOs collude on such issues but the very strength and intensity of the axis may blind one to the deeds of the other.

The problem - in practical terms - is that this does happen in some District Health Authorities and that where this is so, it is likely to seriously undermine the role of the *board* and thus the process of corporate governance. A duopoly is neither what was expected or desired and in circumstances where this is, or is in danger of becoming the case, it is both dangerous and open to abuse. Many of the initiatives taken by Government have been designed to insulate boards from the excesses of over zealous Executives i.e. protecting one 'side' of the board from the

other. The circumstances now, if allowed to develop further, may result in the need to ensure that the 'top' of a board does not create problems for the remainder of their colleagues. These circumstances argue strongly for full strength boards with the diversity and plurality of views this implies and in which all directors are engaged in playing a full and active part under clear and unambiguous leadership conditions.

20.3.2 Getting it Right and Accounting for Performance. Despite initiatives to improve the corporate performance and accountability of the boards of NHS bodies, the findings from this research indicate continuing difficulties in these areas. They suggest that boards appear to take inadequate steps to secure successful policy implementation and remain unclear about and ambivalent towards matters of accountability.

The fundamental problem in terms of corporate performance resides in the fact that the majority of directors - Chairs excepted - are unclear about their statutory obligations and legal responsibilities. Since these lie at the very heart of their *raison d'etre* and thus the conception and construction of their role - and their relationships with fellow directors - this is a critical deficit. This clearly goes some way towards explaining why many District Health Authority boards demonstrate poor scrutiny of policy implementation and Executive

performance. Not only are directors unclear about the extent of their powers and duties - and thus the basis and nature of scrutiny - but the nature and pattern of relations between directors is itself problematic and further reduces the extent, or may distort the motives for, exercising a rigorous overview. The lack of clarity which seems to bedevil Non-Executive directors creates tensions and boundary disputes between themselves and Executive directors. Despite these definitional and role difficulties, however, interpersonal relationships within boards are generally good, indeed congenial, which (ironically) may reduce further notions of independence and thus the likelihood of robust scrutiny.

The findings from this research imply that such difficulties are not uncommon and furthermore are compounded by the received wisdom that detailed scrutiny takes place within the (audit and remuneration) sub committee structure. Although this is plausible (and indeed is the case in some settings) the absence of a consensus as to what constitutes 'directorial essence' would suggest that the reality falls somewhat short of the rhetoric. In any event the responsibility for effective board performance needs to explicitly remain the responsibility of the full board rather than a subset of directors, whatever structural framework they work within. The challenge for the future will be for Government to move away from its position of seeing committees and audit as

the means of detecting and correcting potential failure, to one of encouraging boards to work in a manner which actively seeks success.

Accountability is the other side of this particular coin, for having determined and implemented policy (successfully or otherwise) it is for boards to both give an account and be held to account. The rhetoric of the formal guidance does recognise and indeed encourage the *giving* of an account, publicly, but the emphasis in the sub text is in terms of District Health Authorities being *held* to account centrally. Local accountability clearly having to give way to the identification and location of responsibility - particularly when things go wrong - to the primacy of a relationship with the centre. It is perhaps unsurprising therefore, but no less disturbing, that District Health Authority directors are unclear about accountability and in practice tend to be rather inward looking and defensive. Few boards, for example, have an explicit statement which identifies stakeholders and the organisation's orientation and attitude towards them. The absence of such a document is symbolic of the failure to recognise other and critical interests and the boards obligations towards them.

If the accountability of the institution to the community is suspect or at least incomplete, what of a director's personal accountability to and for self ? The

picture here is also disappointing, for despite a high and laudable commitment to ethical practice, local ethical statements/codes remain rare. The absence of such statements, the values they promote and the personal frame of reference they create makes both the scrutiny process and accounting for performance problematic. Without such statements and the boundaries they define how should directors behave and how should that behaviour - whatever its form - be judged and by whom ? Despite the unfashionable nature of 'values', conflicts of interest are no less common and examples of corrupt behaviour and abuse no less frequent. The present conditions make these difficulties no less likely.

20.4 The Research Questions

This section of the chapter will consider those findings appropriate to and form a conclusion upon the research questions set out in Chapter 1.

20.4.1 Research Question One: To what extent do issues of tenure, gender, age and ethnicity influence the composition and organisation of District Health Authority boards ? The findings from this research clearly demonstrate that these factors are germane to the composition and organisations of District Health Authority boards. In terms of age, directors tend, overall, to be in late middle age, three quarters are male and only a very small proportion come

from a black or ethnic minority background. Particularly significant was the steady increase in the number of women directors - largely Chairs and Non-Executive directors - about half of which have been appointed in the past two years. Despite this, two thirds of all directors have been in post in excess of two years and the majority of Non-Executives come, increasingly, from a private sector background.

These findings suggest that the faces around the boardroom table are indeed changing e.g. with more women, but changing rather slowly with e.g. fewer black and ethnic minority faces than might have been expected. Similarly, the origins of the majority of Chairs/Non-Executive directors is now predominantly from the private sector which, when combined with the above 'demographic' changes, is suggestive of some degree of cultural change in the boardroom. Examples here include the different directorial style that female directors bring (Williamson,1995) or the orientation of boards increasingly informed by the private sector antecedents of their directors as in case study Omega. These influences for change are, however, counter balanced by the middle aged and somewhat conservative cast of the directorial gene pool and the fact that many directors have been directors for some time. Indeed, more than a third of Chairs had held office for more than five years. The picture is suggestive of some change in the boardroom, but with the potential for age and value

tensions between Executives and Non-Executives being compounded by uncertainties surrounding their respective roles - as demonstrated in case studies Alpha and Beta. Overall, rather more continuity than change - which concurs with the findings of (Cairncross *et.al.*, 1991). In organisational terms the advent of female directors may have organisational consequences for the timing and duration of board meetings to accommodate to women's working (case study Beta), domestic (case study Alpha) or health (case study Omega) circumstances. Similarly the sporting metaphor and the combative style of some boardrooms may have to accommodate style and language differences brought by women and - were they exist - directors from a black and ethnic minority background.

20.4.2 Research Question Two: To what extent can behaviours consistent with Tricker's categories of direction, executive management, supervision and accountability be identified and thus the existence of corporate governance demonstrated in District Health Authority boards ? In reaching a conclusion upon this particular research question it is important to recall that the logic of the *Working for Patients* reforms was, in part at least, to change the rationale of District Health Authorities to the accompaniment of major structural and processual change. Furthermore, that these changes were sufficiently similar to corporate governance in the private sector to be of significance and therefore of research interest. An

exhaustive review of the literature cast much light upon such matters but the work of Tricker (1984) offered a conceptual framework which both defined corporate governance and identified its four principal domains i.e. direction, executive management, supervision and accountability. In the light of the Health Authority/Member literature the author was able to operationalise the domains - within a public sector/health care context - in terms of questions appropriate to the postal survey and interviews/observations appropriate to the subsequent case study analysis.

The detailed findings have been considered in earlier chapters and are, in any event, set out in summary form in **Fig 20.2** above. These clearly demonstrate that the Tricker formulation was an appropriate theoretical basis for this research, that the data *do* reveal patterns of working consistent with the four domains and therefore, empirically, demonstrate the existence and operation of corporate governance in English District Health Authorities.

In a subsequent refinement of the original formulation Hilmer & Tricker (1990) developed additional facets to the model of corporate governance - see **Fig 5.4** If we consider these alongside the meta conclusions set out in 20.3.1 and 20.3.2 above, although the language does not match exactly, it is sufficiently close to compare the domains/findings

from this research with the refinements to the model. In terms of the outward looking plane, the findings from this research would suggest that District Health Authorities are insufficiently outward looking being less than optimally engaged with stakeholders and performing poorly in terms of expressed accountability. In regard to the inward looking plane District Health Authorities are well focused in terms of establishing strategy (direction) but less strong in terms of policy making (executive management), the latter being distorted by the differential strength and contribution of the Chair/CEO and the Non-Executives/ Executives. Finally, a comparison of the performance and conformance role(s) would suggest that District Health Authorities are rather more effective in respect of the former than the latter. The strength of the performance role may reside in the fact that much of a District Health Authority's strategic agenda is, in effect, set for the board by Government and, increasingly, framed in financial terms. By contrast - and despite much guidance - supervision and accountability need to be initiated locally 'from within out' which is clearly problematic. In terms of the research question, therefore, boardroom behaviour consistent with Tricker's original formulation (and its subsequent refinement) has been shown which, de facto, demonstrates the existence of corporate governance.

20.4.3 Research Question Three: To what extent are such patterns of working consistent with the *Working for*

Patients **reforms, subsequent Codes of Conduct and Accountability, and, with the recommendations of the Nolan Committee ?** In reaching a conclusion about the *Working for Patients* reforms it is important to recall that they were, in some measure, a response to a lack of clarity concerning the role of the Health Authorities and to serious concerns about the minimal influence of their members upon policy. The findings from this research clearly show that District Health Authorities are now actively engaged in their new, more explicitly defined role of purchasing authority, within the framework of the NHS internal market. The managerialist structural and cultural shift from 'public authority' to small, focused and business-like 'board' has also taken place. However, some difficulties remain, with lack of clarity having moved from the role of the Health Authority to that of the newly created role of Non-Executive director. In addition, the evidence also suggests that the impact of Non-Executive directors on strategy bears a remarkable similarity to the earlier influence of members upon policy. We can conclude therefore that the process of reform has taken root and has overcome some of the previous problems experienced by Health Authorities. Regrettably some problems remain and new difficulties have emerged.

The process of reform - initially only partially understood and implemented in haste - required an almost instantaneous transition from the long established manner

of NHS working to one consistent with a task centred/results orientated culture where ends have assumed more importance than means. These conditions created some spectacular problems which eventually resulted in the publication of the Codes of Conduct and Accountability (DOH, 1994). The findings from this research clearly show that boards have responded appropriately to these in terms of an increased awareness of public sector values, sensitivity to issues of personal gain/declarations of interest, expenditure on hospitality and the establishment of audit and remuneration committees. However, despite guidance on openness, the need for meaningful relations with a wide range of stakeholders and a requirement to account to a range of interests, problems in these areas remain undiminished. The greatest shortfall, however, stems from the guidance on Non-Executive directors - which was characterised in terms of their contribution to specific board *activities* - rather than to a wider *process*. This deficit is evident in the manner in which many Non-Executive directors make their contribution to the board and is itself worthy of further study in terms of the style variations available and the individual and/or contextual circumstances which condition their selection or rejection (Styles & Taylor, 1996). The greater uncertainty, however, is rooted in the lack of understanding by NHS directors themselves, made manifest (again) in calls to review and define their role (Anon, 1996).

A generalised concern about the conduct of those in public life and about the nature of public appointments led to the establishment of the Nolan Committee and the publication of its first report in May, 1995 (Cm 2850-1, 1995). Whilst forming a conclusion about Nolan may be premature, the findings from this research demonstrate that Nolan has successfully reinforced the primacy of values, made a code of conduct for board members mandatory and strengthened the role of accounting officers (subsequently extended to include an "accountable officer" (BN/5/95, 1995) in each District Health Authority) within the NHS. Other important sequelae of Nolan were the regularising of public appointments under the auspices of a Commissioner for Public Appointments who, himself, later published a Code of Practice for Public Appointments Procedures (OCPA, 1995).

We are able **to conclude** therefore that the *Working for Patients* "better management" reforms have been implemented as has much of the subsequent guidance published in the form of the Codes of Conduct and Accountability (DOH, 1994) or as a consequence of the first report of the Nolan Committee. What is also clear is that:

* there is a lack of clarity about the Non-Executive director role and as a consequence uneven performance

* Non-Executive directors have a marginal influence upon strategy

* boards are less open and transparent than might be

* few boards have an explicit statement which identifies stakeholders and the organisation's orientation and attitude towards them

* accountability 'outwards' (rather than 'upwards') remains problematic, and,

* significant conflicts of interest remain.

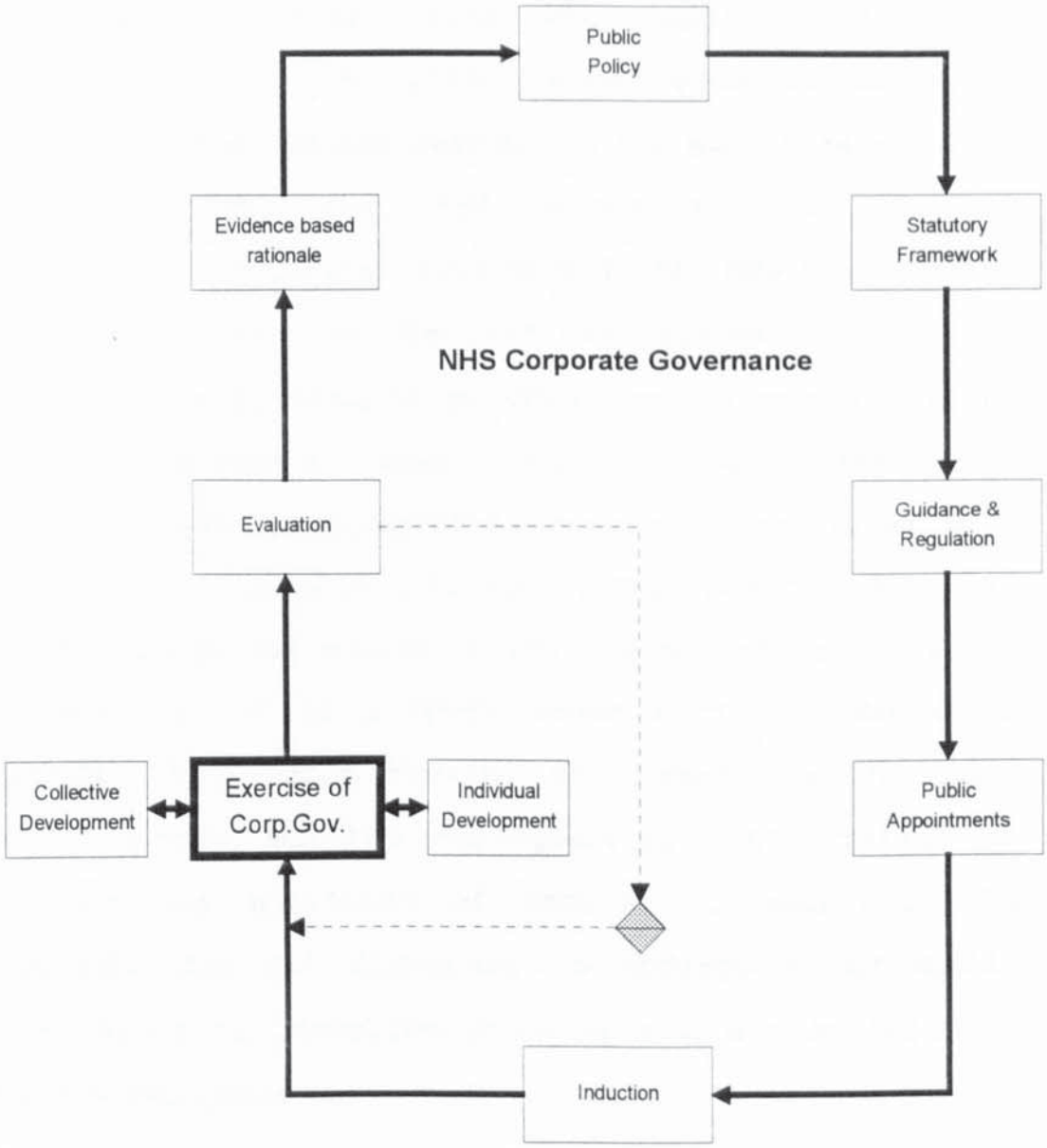
20.4.4 Research Question Four: What implications do the findings have for the development of District Health Authority directors ? Chapter 14 reported and discussed the issues of development in full and, like it, in reaching a conclusion it is important to think in terms of the needs of directors collectively in the form of organisational development and for individuals in terms of personal development.

Turning to personal development first, it is clear that induction - to *all* director roles should become mandatory - and would be a suitable platform to address some of the knowledge based problems. In addition to existing content, induction should also address the issues of the statutory obligations and legal responsibilities of directors (especially Non-Executive directors), the role and contribution of Non-Executive directors in strategy formulation, managing/declaring conflicts of interest, and, the differential contribution of all directors. As a consequence directors would have both greater absolute and relative certainty.

Some of the other areas of difficulty identified in this research are more susceptible to collective approaches to development. These difficulties are concerned with the manner in which the board - as opposed to individuals - should behave and perform. They include ensuring a proper degree of transparency, collaborative relations with stakeholders, effective scrutiny, the articulation of local values and the effective expression of accountability. These are matters most appropriately considered in the context of a regular review of the way in which the board works and require - as a prerequisite - a commitment to improving board *process*. Such reviews require the prior establishment of local criteria and the existence of an appropriate framework. The publication recently of *Good Practice for Directors: Criteria for NHS Boards* (IOD, 1996) provides an excellent basis for conducting such reviews and thus the opportunity to confront problematic process and performance.

Comprehensive development, however, must also address the evolution of NHS corporate governance in the round and not just the individuals and institutions concerned - see **Fig 20.3** It is clear that the statutory framework and the making of appointments to public bodies are still evolving areas; individual/collective development a *sine qua non*. The remaining elements - critical to a healthy developmental cycle - are the need for centrally sponsored evaluation, the findings from which should inform the

Fig 20.3
NHS Corporate Governance
Developmental Cycle



process of refinement or further reform. Government has consistently shown itself reluctant to formally and publicly evaluate the *Working for Patients* reforms or make explicit the assumptions upon which these reforms were promulgated. Whilst this remains the case the further development of NHS corporate governance is likely to remain erratic and, ultimately, incomplete.

20.4.5 Research Question Five: What implications do the findings have for the further development of corporate governance in the NHS and throughout the public sector ? In considering first the implications for the further development of corporate governance **in the NHS** these can be thought of in terms of the need for further legislation, the issue/strengthening of guidance, and, a requirement to revisit and reframe a number of more fundamental issues. In terms of statutory change this can be accomplished with recourse to the issue of a Statutory Instrument rather than new legislation and should revise the definition of board size from "up to" to a "requirement for" five Executive directors. This would reverse the trend towards under strength boards and the consequential concentration of power and the narrowing of debate. In addition, the requirement for all directors to undergo a nationally agreed period of induction/training should also become a statutory obligation.

Further development and progress - *within the current paradigm* - is also possible through the issue of new or the strengthening of existing guidance. Particular emphasis needs to concern the need for boards to be the vehicle for seeking corporate success through the active development and pursuit of an appropriate strategy, rather than the largely passive focus of scrutiny and accountability to the centre. The shift in emphasis that this would require would demand a fundamental reorientation by the centre supported by prescribed behaviour for the involvement of directors in the strategy process. Guidance should also require each District Health Authority to formulate its own ethical statement which would set out local standards and commitments within the wider framework of values established in the Code of Conduct (DOH, 1994). While such statements might be thought of as ornamentation they stand comparison with an organisation's Health & Safety at Work policy i.e. a public declaration and commitment to a particular manner of working against which future performance can be judged.

The greater challenge, however, will be to progress NHS corporate governance - *beyond the current paradigm*. The two principal areas concern the role of the Non-Executive director and the issue of the nature and focus of accountability. There are no easy answers. Each needs to be revisited, redefined and reframed. The former on the basis that problems still exist concerning the nature and

contribution of the Non-Executive director. The latter on the basis that accountability is profoundly unsatisfactory. Both are reflected in the wider corporate governance debate in terms of Cadbury II (Anon, 1995) and in the role of business in society (Harvey, 1996). Such movement, however, relies upon evidence - evidence government seems reluctant to collect let alone examine - despite its exhortations for the NHS to embrace "evidence based" medicine (NHSE, 1995b).

In terms of the implications **throughout the public sector** these can be thought of as illuminating existing and complementary patterns of governance in other arenas, or, informing policy choice in regard to further/future public sector reform. In very general terms these can be thought of under four broad headings. Firstly, that Tricker's formulation (1984; also Hilmer & Tricker, 1990) is a model of corporate governance appropriate to defining and exploring such matters in public sector settings. Secondly, that it is crucial that director's roles and duties are fully and adequately defined *a priori*. Thirdly - and particularly important in a public sector context - the nature and expression of accountability needs to be appropriate, acceptable and effective in terms of the organisation's role and history. Finally, there must be a preparedness to evaluate in terms of measuring progress, identifying strengths and limitations, and, setting an agenda for development and success.

20.5 Strengths and Limitations

Perhaps one of the most important dilemmas faced by researchers is the extent to which their findings are generalizeable - the degree to which they reflect and inform the 'reality' beyond the boundaries of empiricism. Inevitably such a question returns us to issues of methodology and methods, for it is in their selection, implementation and - most of all - in their virtues, that the answers lie.

Denzin (1970, p297) defined triangulation as "the combination of methodologies in the study of the same phenomenon" which he asserts have greater validity and reliability than a single methodological approach. Triangulation is also described as a multi-method/multi-trait approach or as "convergent validation" (Campbell & Fiske, 1959), particularly where complementary qualitative and quantitative methodologies are combined. For these reasons the design of this research sought to combine:

* a quantitative postal survey encompassing all District Health Authority directors within the boundaries of three Regional Health Authorities, and,
* three (qualitative) case studies conducted over time and involving data collection from interviews, observations and documentary sources.

Prior to the fieldwork the importance of both validity and reliability were identified. Steps were taken to ensure that construct validity (multiple methods and the

establishment of a data trail), internal validity (pattern matching, explanation building and time series), external validity (multiple case studies) and reliability (procedural consistency) were all addressed.

In terms of the quantitative dimension, generalization depends upon sampling theory, determining sample size and selecting a representative sample (Rea & Parker,1992). The sample was 332 District Health Authority directors from within the boundaries of 3 Regional Health Authorities i.e. 20% of the RHAs then in existence. In terms of the directors themselves (MORI, 1993) suggests that a sample of 200 should give at least ± 7% margin of error with 95% confidence. Thus the survey sample was both adequate and sufficiently representative to be able to generalize with confidence. "Using a quantitative approach, however, one can only make generalizations about the sample to the population" (Hartley, 1994 p225).

The case studies were undertaken (in part) to test the "ecological fallacy" (Robinson, 1950) - thus further validating the survey findings - and, more importantly, to study the process of corporate governance and the influence of context upon its expression and practice. Here again, selection of the 'sample' was important. The selection of more than one case is the means of significantly increasing confidence in the findings *per se*; of the three specific cases the means of reflecting rural, urban and metropolitan

contextual variation. Within each case study data were collected from semi-structured interviews, observations and documentary sources. As Hartley (1994, p 225) observes:

> "The detailed examination of processes in a context can reveal processes which can be proposed as general or as peculiar to that organization. The detailed knowledge of the organization and especially the knowledge about the *processes* underlying the behaviour and its *context* can help to specify the conditions under which the behaviour can be expected to occur. In other words, the generalization is about theoretical propositions not about populations."

Finally, publication is an important means of establishing validity. The publication of the findings from the pilot study (Harrison, 1994) and the submission of evidence from the pilot study and from the main survey to the NHS Corporate Governance Task Force and to the Nolan Committee respectively are important attempts to demonstrate validity. The summaries of the case studies were also sent in draft form to be reviewed by the Chair and Chief Executive in each case study Authority. Their comments on points of fact and observations on interpretation again validating the findings and thus increasing the confidence one can have in their generalization.

Turning now to the **limitations** of the research, these stem from the implications of the work being undertaken by a single researcher and from conducting complex research over an extended period. Denzin (1984), in addressing

triangulation extolled the virtues of "investigator triangulation" as a means of reducing or eliminating individual bias. Inevitably in single handed research this is a potential danger. Particular efforts were therefore made to increase internal validity by relating survey and case study findings to the *a priori* theoretical constructs rather than simply providing description, and, in terms of the case studies, having key actors review the findings. Such steps recognised yet minimized the dangers inherent in a single researcher study.

The greater problem was the length of the research process itself, both in terms of the stability of the subject and the timeliness of the findings. The length of the research is a product of both the complex design and the practical and academic constraints of part-time doctoral research. The effects of the passage of time required both a singular strength of purpose, yet a sufficiently open and flexible approach which recognised and allowed for the effects of intercurrent changes. One strategy was to make a virtue out of length and include a longitudinal dimension to the case studies; the other was to note significant contextual change and thus consider the findings in both absolute and relative terms (see Chapter 19). Perhaps the greatest problem, however, was the legislative and consequential structural changes which took place towards the end of the research which cast an almost 'historical' light upon the findings. The possibility that

this might indeed prove to be the case therefore required a research design which would transcend such temporal pressures. Accordingly, the particular findings should be seen as both illuminating corporate governance in District Health Authorities and also in the boards of health bodies more generally.

In summary we can conclude that the strengths and limitations of the research are as follows. The **strengths** lie in:

* a triangulated/multi-method design
* practical steps being taken to maximise construct/internal/external validity and also reliability
* a robust and representative sample for the postal survey enabling generalization to the population with confidence, and,
* the use of multiple/multi-method/longitudinal case studies enabling theoretical generalization with confidence

The **limitations**, which are few, concern:

* the potential danger of a single researcher study, and,
* the length of the research.

20.6 Contribution to the Literature

This research is important in terms of both its particular findings (see 20.3 and 20.4 above) and for the distinctive contribution it has made to a number of differing literature(s). In the first instance the research

makes a substantial and original contribution to the NHS **core literature on Health Authorities/ Members**. Substantial for it is one of only two major studies to investigate the operation of the new style 'boards', the other being the work of Pettigrew *et.al.* (1991-93) (see Chapter 6). Even in this context, however, it is unique in framing the study within the precepts of corporate governance and in applying Tricker's constructs (1984; also Hilmer & Tricker 1990) to its investigation. As noted above, and despite the fact that these particular data refer to District Health Authorities, the findings from the study also contribute to a **wider NHS debate/literature concerning governance** and the performance of the boards of *all* health bodies.

The research has also made an important contribution to **the public sector management literature** in so far as managerialist changes of the type studied in this research are not confined to the NHS. A number of public sector institutions either have introduced private sector style boards e.g. in Schools and Colleges or are proposing to do so e.g. Police Authorities. This research provides relevant findings and an intellectual framework for the former and material to inform policy choice and development in respect of the latter. Thirdly, in terms of **the management research literature** the research design introduced some measure of innovation to the study of such matters. Whilst not unique, the study certainly reinforces the value of multi-methods, particularly the combination of quantitative and

qualitative dimensions. In addition the value of the case study as, perhaps, the most effective means of identifying and exploring sensitive management processes was also reinforced (Stake, 1995).

Finally, the research makes a substantial and unique contribution to **the corporate governance literature.** By definition, almost, this literature is concerned with the operation of boards and the direction of companies at the highest level in the *private* sector. This research has shown that the precepts of corporate governance and Tricker's constructs are both appropriate and relevant to corporate governance in the public sector and that corporate governance is, now, a legitimate and important topic for the reformed NHS. As such this study makes a substantial and original contribution to this essentially private sector literature. Notwithstanding its NHS/health focus, on balance, the greatest significance of the research is in its contribution to the corporate governance literature.

20.7 Further Research

Research, inevitably, raises almost as many questions as it answers and this study proved to be no exception. Chapter 19, which discussed the findings at length, identified the questions and thus the opportunities and requirements for further research. These are summarised in **Fig 20.4** below.

Fig 20.4
Areas of Further/Future Research

The findings of the research reported herein suggests the need to investigate...	
1	the differential nature and impact of male and female directors.
2	the impact of differential board size on board and corporate performance.
3	the importance of director background upon individual contribution and performance.
4	the extent to which explicit stakeholder relations impacts upon legitimacy, performance & accountability.
5	the means of involving the public in - and accounting to the public for - the work of DHA boards.
7	the need to investigate the nature of the NED role.
8	the need to evaluate the role and contribution of the DHA 'Secretary to the Board' appointments.
9	the most appropriate ways for boards to scrutinize the implementation of policy and executive performance.
10	the need to evaluate the corporate role of the executive director.

What stands out from such an agenda is just how little is understood about the exercise of corporate governance in the contemporary NHS, and, the extent to which some questions are common to both the private and public sectors e.g. the need to more fully understand the nature of and contribution by the Non-Executive director.

Such an agenda does, however, challenge all those involved. It challenges Government to evaluate policy and to move towards (ideally) an 'evidence based' approach to policy development. It also challenges researchers to

develop methods and theories to undertake good science and also challenges directors themselves to understand fully and exercise competently their part in a societally important process.

20.8 Reflections upon Corporate Governance: Recent History and Future Prospects

In looking backwards - and indeed forwards - one is struck by the inextricable nature of the links between the practice and prospects for corporate governance in the private sector and in the public sector. The pattern of escalating concern about boardroom behaviour, executive reward, the lack of interest by shareholders and some spectacular collapses in the private sector bear a striking similarity to the public sector experience. In terms of the NHS, for example, the emergence of General Managers - "the praetorian guard of the new managerialism" (Jenkins, 1995 p69) - the managerial discretion they enjoyed, issues of public accountability and equally spectacular scandals became depressingly familiar as the obverse and public sector face of the corporate governance coin.

A determination to rectify these difficulties was, however, soon apparent. The private sector established the Cadbury, Greenbury and now Hampel committees to consider particular problems and to formulate authoritative responses. A pattern repeated in the NHS through the intervention of Parliament and the establishment of the

Corporate Governance Task Force; subsequently augmented by the more broadly based Nolan Committee.

Perhaps because these issues have been seen to be addressed (with a consequential lowering of public concern) there now appears to be an almost visible falling back from the debate and a recanting of some of the earlier interventions. From those who challenged Cadbury (Kelly, 1996), Greenbury (Anon, 1995) or simply reform *per se* (Lewis, 1995; Lewis 1996b) - retreat is clearly evident. This may of course be complacency, but more probably it is a desire to see such matters return to the shadows where scrutiny is less frequent and certainly less searching. This is not to imply that the conspiracy theory is the obvious or only explanation but, perhaps, that the nature of corporate governance is too entrepreneurial, pragmatic and fluid to ever be completely and/or permanently defined and regulated. If this is the case, we will need to reconcile ourselves to periodic scandal as individual directors or boards - in either sector - test and transgress the boundaries of what is regarded as acceptable.

Alternatively, it may be that insufficient understanding of corporate governance - even amongst those who exercise it - may have resulted in the naive and mistaken belief that the present superficial tranquillity is an indication that all is well. Nothing could be further from the truth with danger signals and unease apparent in

both sectors. The issue of executive reward (Taylor, 1996) and concerns about both the supply (Kelly, 1995) and the role of the Non-Executive director (Lewis, 1996a) are alive and well in the private sector and reported to be items on the Hampel Committee agenda (Anon, 1995). The Barings collapse - almost a lightening conductor for contemporary and (again) growing concern - is a focus for anxieties about empowerment (Weaving, 1995) and supervision/scrutiny (Atkins, 1995). Nor are such concerns confined to the private sector, with recent scandalous behaviour exposed in the former Northern RHA (HC280, 1996) and in the NHS Executive itself (Cross, 1996). Although the former example predated the *Working for Patients* reforms it is interesting that it has taken years for it to come to light in a post reform and post Codes of Conduct and Accountability environment. Similarly the problems at the NHS Executive, which centre upon a major IT project, are sufficiently similar to bear an uncanny resemblance to earlier events at the Wessex RHA for the PAC to have drawn a similar and critical comparison (Wighton, 1996). Again the questions: what of corporate governance ? what of the directors ? what of supervision ?

We are drawn to one of two conclusions. Either our understanding of corporate governance, its practice and regulation are not fully mature, or, the manner in which we define business - private or public - and its relationship with society is inadequate. Both are probably true, but

especially the disjunction between present definitions and society's expectations. Something of this discontinuity - and the resultant anxiety about and reform of corporate governance - is perhaps also evident in Germany (Fisher, 1995), France (Jack, 1995) and the US (Jackson, 1995).

The solutions, like the problems, appear to be twofold. At the most basic we must increase our understanding of the topic, create appropriate legal and organisational structures and in addition define, develop and regulate the activities of directors and boards. 'Theoretical' considerations are also pertinent, for stewardship theory (Donaldson & Davis, 1988)) has become problematic. In the private sector, this is largely because shareholders fail to exercise their duties and obligations because "the interests of owners and management [are] likely to diverge" (Tricker, 1994 p102), and, in the public sector, because no (effective) stakeholder relationships have been established. Consequently, in both instances agency costs (Berle & Means, 1932; Pratt & Zeckhauser, 1985) have been high. A second strand in working towards a robust framework for corporate governance must therefore be to (re)define the nature of 'ownership' and the obligations/expectations which attach to it. For it is only by engaging people in meeting such obligations - in both the private and the public sector business - that we can avoid simply and only looking to solutions in increased regulation.

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Appendix 1

Postal Questionnaire:

Pilot Study

Reforming District Health Authorities

Please complete all of the following questions as indicated by ticking the one box which most closely approximates to your view. In addition, please add any further comments you wish at question 40.

1.	Are you a . . .	chairman	[ ] (1)
		non executive member	[ ] (2)
		chief executive	[ ] (3)
		executive member	[ ] (4)
2.	Have you occupied your present role as chair, non executive, chief executive or executive member for . . .	less than 2 years	[ ] (1)
		2 - 5 years	[ ] (2)
		more than 5 years	[ ] (3)
3.	Are you . . .	male	[ ] (1)
		female	[ ] (2)
4.	Are you aged between . . .	30 - 39	[ ] (1)
		40 - 49	[ ] (2)
		50 - 59	[ ] (3)
		60 - 69	[ ] (4)
		70 - 79	[ ] (5)

Executive members are now asked to complete questions 5 and 6, skip question 7, and then to complete all remaining questions commencing with question 8.

Non executive members are now asked to skip questions 5 and 6, and then to complete all remaining questions commencing with question 7.

5.	As an executive member are you a . . .	general manager	[ ] (1)
		director of finance	[ ] (2)
		director of public health	[ ] (3)
		director of purchasing	[ ] (4)
		other	[ ] (5)
		please specify _____	
6.	As an executive member is your background . . .	medical & dental	[ ] (1)
		nursing & midwifery	[ ] (2)
		admin. & clerical	[ ] (3)
		prof. & technical	[ ] (4)
		other	[ ] (5)
7.	As a non executive member would you describe your employment as . . .	private sector	[ ] (1)
		public sector	[ ] (2)
		unemployed	[ ] (3)
		retired	[ ] (4)
		other	[ ] (5)
8.	Has the Authority defined a role for itself which adds value ?	yes	[ ] (1)
		no	[ ] (2)
		don't know	[ ] (3)
9.	Has the Authority thoroughly discussed its purpose ?	yes	[ ] (1)
		no	[ ] (2)
		don't know	[ ] (3)
10.	Has the Authority established a mission statement for itself ?	yes	[ ] (1)
		no	[ ] (2)
		don't know	[ ] (3)
11.	Does the mission state to whom and for what the Authority will be held accountable ?	yes	[ ] (1)
		no	[ ] (2)
		don't know	[ ] (3)

12.	Does the mission outline the values the Authority will use as the basis of its judgements ?	yes no don't know N/A	[ ] (1) [ ] (2) [ ] (3) [ ] (4)
13.	Which is the most important strategic issue facing the Authority at this time ?	boundaries/merger contracting commissioning finance legal matters marketing personnel research & development technology other please specify _____	[ ] (1) [ ] (2) [ ] (3) [ ] (4) [ ] (5) [ ] (6) [ ] (7) [ ] (8) [ ] (9) [ ] (A)
14.	Have priorities from amongst the above topics been set for member involvement ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
15.	Is there a shared sense of corporate identity ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
16.	Is there clarity about the boundary between the chairman and the chief executive ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
17.	Have any of the following committees been established ?	audit remuneration management review	[ ] (1) [ ] (2) [ ] (3)
18.	Are there sufficient additional committees to support the role of members ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)

19.	Do all committees have a clear mandate ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
20.	Is there a clear understanding about the nature and timing of the information that should be provided to the Authority ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
21.	Does the information provided to the Authority support monitoring and strategic control ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
22.	Does the Authority meet publicaly ?	1 - 3 times pa 4 - 6 times pa 7 - 9 times pa 10 - 12 times pa	[ ] (1) [ ] (2) [ ] (3) [ ] (4)
23.	Does the atmosphere in the board-room encourage frank discussion and permit both executives and non executives to challenge assumptions ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
24.	Can executives and non executives disagree with the chairman and therefore influence the chairman's decision ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
25.	Do all executives and non executives have the opportunity to place items on the Authority agenda ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
26.	By which means does the Authority take decisions ?	diktat voting consensus does not	[ ] (1) [ ] (2) [ ] (3) [ ] (4)

27.	Do opportunities exist for informal interaction between executive and non executive members ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
28.	Is there a way for the Authority to review its own working style on a routine basis ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
29.	Is there an induction/orientation programme for new executive and non executive members ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
30.	Have all executive and non executive members been given information concerning their statutory obligations and legal responsibilities ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
31.	Which one of the following best describes your contribution as an executive or non executive member ?	specialist generalist corporate	[ ] (1) [ ] (2) [ ] (3)
32.	Who in your opinion makes most decisions ?	executives non executives	[ ] (1) [ ] (2)
33.	Does the chairman review the contribution of non executive members on a regular basis ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
34.	Do the chairman and non executives regularly schedule reviews of executive members ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)

35.	Who has the *most* significant influence upon your role as an executive or non executive member within the Authority ?	chairman non executives chief executive executives peers	[ ] (1) [ ] (2) [ ] (3) [ ] (4) [ ] (5)
36.	How would you describe the relationship between executive and non executive members ?	close cordial tense distant	[ ] (1) [ ] (2) [ ] (3) [ ] (4)
37.	Do you think it is important for the Authority to behave in an ethical manner ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
38.	Does the organisation have an explicit ethical code or frame-work and does it address the operation of the Authority ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
39	Has any non executive member declared any potential conflict of interest ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)

40 If you wish, please feel free to add any other comment which might add to an understanding of how the reconstituted District Health Authorities operate.

Thank you for completing this questionnaire. Please place it in the stamped & addressed envelope provided and return it promptly.

Appendix 2

Postal Questionnaire:

Main Survey

Reforming District Health Authorities

Please complete all of the following questions as indicated by ticking the box which most closely resembles your view. In addition, please add any further comments you wish at question 43.

1.	Are you a . . .	chair	[ ] (1)
		non executive director	[ ] (2)
		chief executive	[ ] (3)
		executive director	[ ] (4)
2.	Have you occupied your present role as chair, non executive, chief executive or executive director for . . .	less than 2 years	[ ] (1)
		2 - 5 years	[ ] (2)
		more than 5 years	[ ] (3)
3.	Are you . . .	male	[ ] (1)
		female	[ ] (2)
4.	Are you aged . . .	under 40	[ ] (1)
		40 - 49	[ ] (2)
		50 - 59	[ ] (3)
		60 - 69	[ ] (4)
		over 70	[ ] (5)
5.	Which ethnic group do you consider you belong to ?	White	[ ] (1)
		Black Caribbean	[ ] (2)
		Black African	[ ] (3)
		Black (other)	[ ] (4)
		Indian	[ ] (5)
		Pakistani	[ ] (6)
		Bangladeshi	[ ] (7)
		Chinese	[ ] (8)
		Asian (other)	[ ] (9)
		Other, please specify_____	[ ] (A)

Executive directors are now asked to complete questions 6 and 7, skip question 8, and then complete the remaining questions.

Non executive directors are now asked to skip question 6 and 7, and then complete the remaining questions.

6.	As an *executive* director are you a . . .	general manager	[ ] (1)
		director of finance	[ ] (2)
		director of public health	[ ] (3)
		director of purchasing	[ ] (4)
		other,	[ ] (5)
		please specify _____	
7.	As an *executive* director is your background . . .	medical & dental	[ ] (1)
		nursing & midwifery	[ ] (2)
		admin. & clerical	[ ] (3)
		profs allied to medicine	[ ] (4)
		prof. & technical	[ ] (5)
		other	[ ] (6)
8.	As a *non executive* director would you describe your employment background as . . .	private sector	[ ] (1)
		public sector	[ ] (2)
		unemployed	[ ] (3)
		retired	[ ] (4)
		other	[ ] (5)
9.	Has the Authority discussed and agreed a statement of its purpose ?	yes	[ ] (1)
		no	[ ] (2)
		don't know	[ ] (3)
10.	Has the Authority explicitly defined its own role ?	yes	[ ] (1)
		no	[ ] (2)
		don't know	[ ] (3)
11.	Has the Authority established a mission statement for itself ?	yes	[ ] (1)
		no	[ ] (2)
		don't know	[ ] (3)

If the answer to question 11 above was "no" or "don't know", go to question 14.

12.	Does the mission state to whom and for what the Authority will be held accountable ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
13.	Does the mission outline the values the Authority will use as the basis of its judgements ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
14.	Which is the ***single*** most important strategic issue facing the Authority at this time ?	boundaries/merger contract/commission finance legal matters marketing personnel research & development technology other, please specify _____	[ ] (1) [ ] (2) [ ] (3) [ ] (4) [ ] (5) [ ] (6) [ ] (7) [ ] (8) [ ] (9)
15.	Have priorities from amongst the above topics been set for member involvement ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
16.	Is there a shared sense of corporate identity ?	very clearly defined reasonably defined poorly defined not at all defined don't know	[ ] (1) [ ] (2) [ ] (3) [ ] (4) [ ] (5)
17.	Is there clarity about the boundary between the chair and the chief executive ?	complete clarity reasonable clarity little clarity no clarity don't know	[ ] (1) [ ] (2) [ ] (3) [ ] (4) [ ] (5)

18. Has consideration been given to appointing a Company Secretary to advise the Authority ?

yes	[ ] (1)
no	[ ] (2)
don't know	[ ] (3)

19. Have any of the following committees been established ?

	yes	no	don't know
* audit	[ ] (1)	[ ] (2)	[ ] (3)
* remuneration	[ ] (1)	[ ] (2)	[ ] (3)
* management review	[ ] (1)	[ ] (2)	[ ] (3)
* other committees, please specify _____	[ ] (1)	[ ] (2)	[ ] (3)

20. Do all committees of the Authority have a clear mandate ?

all do	[ ] (1)
most do	[ ] (2)
few do	[ ] (3)
none do	[ ] (4)
don't know	[ ] (5)
N/A	[ ] (6)

21. Does the information provided to the Authority support monitoring and strategic control ?

completely	[ ] (1)
to a reasonable degree	[ ] (2)
to a limited degree	[ ] (3)
not at all	[ ] (4)
don't know	[ ] (5)

22. Does the Authority meet publicly ?

1 - 3 times pa	[ ] (1)
4 - 6 times pa	[ ] (2)
7 - 9 times pa	[ ] (3)
10 - 12 times pa	[ ] (4)

23 Does the Authority publish an Annual Report ?

yes	[ ] (1)
no	[ ] (2)
don't know	[ ] (3)

24. Does the atmosphere in the board-room encourage frank discussion and permit both executives and non executives to challenge assumptions ?

always	[ ] (1)
mostly	[ ] (2)
rarely	[ ] (3)
not at all	[ ] (4)
don't know	[ ] (5)

25.	Can executives and non executives disagree with the Chair and therefore influence the Chair's decisions ?	always mostly rarely not at all don't know	[ ] (1) [ ] (2) [ ] (3) [ ] (4) [ ] (5)
26.	Do all executives and non executives have the opportunity to place items on the Authority's agenda ?	ample opportunities some opportunities very few opportunities no opportunity don't know	[ ] (1) [ ] (2) [ ] (3) [ ] (4) [ ] (5)
27.	By which means does the Authority usually take decisions ?	diktat voting consensus other, please specify _____	[ ] (1) [ ] (2) [ ] (3) [ ] (4)
28.	Is there a review mechanism by which directors can ensure the implementation of Authority decisions ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
29.	Do opportunities exist for informal interaction between executive and non executive directors ?	very frequently occasionally seldom not at all don't know	[ ] (1) [ ] (2) [ ] (3) [ ] (4) [ ] (5)
30.	Does the Authority review its its own working style on a regular basis ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
31.	Is there an induction/orientation programme for new executive and non executive directors ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)

32.	Have all executive and non executive directors been given information concerning their statutory obligations and legal responsibilities ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
33.	Which one of the following best describes your contribution as an executive or non executive director ?	specialist generalist other, please specify_____	[ ] (1) [ ] (2) [ ] (3)
34.	Who in your opinion makes most decisions ?	executives non executives don't know	[ ] (1) [ ] (2) [ ] (3)
35.	Does the Chair review the contribution of non executive directors on a regular basis ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
36.	Do the Chair and non executives regularly schedule reviews of executive directors ?	yes no don't know	[ ] (1) [ ] (2) [ ] (3)
37.	Who - within the Authority - has the *most* significant influence upon your role as an executive or non executive director.	chair non executive directors chief executive executive directors	[ ] (1) [ ] (2) [ ] (3) [ ] (4)
38.	Which word best describes the relationship between executive and non executive directors?	close cordial tense distant don't know	[ ] (1) [ ] (2) [ ] (3) [ ] (4) [ ] (5)

39. Does the Authority have an agreed and published statement as to how it would wish to behave towards...

		yes	no	don't know
*	the public	[ ] (1)	[ ] (2)	[ ] (3)
*	providers	[ ] (1)	[ ] (2)	[ ] (3)
*	its own employees	[ ] (1)	[ ] (2)	[ ] (3)
*	other NHS bodies	[ ] (1)	[ ] (2)	[ ] (3)

40. Do you think it is important for the Authority to behave in an ethical manner ?

yes [ ] (1)
no [ ] (2)
don't know [ ] (3)

41. Does the organisation have an explicit ethical code or framework ?

yes [ ] (1)
no [ ] (2)
don't know [ ] (3)

42. Has any non executive director in *your* Authority declared a pecuniary or material conflict of interest ?

yes [ ] (1)
no [ ] (2)
don't know [ ] (3)

43. Please feel free to add any other comments which might add to an understanding of how the reconstituted District Health Authorities operate.

Thank you for completing this questionnaire. Please place it in the stamped and addressed envelope provided and return it promptly.

Appendix 3

Case Study

Interview Framework

Corporate Governance

Case Study

Case Site _____

Interviewee _____

Context

	Intv	Doc	Obs
1. Structure & size of Board *(Working for Patients*, merger etc)			
2. Continuity or Change (number of new members, gender/age/ ethnicity, qualities/experience)			
3. Fuss about Corporate Governance (private sector board, Cadbury, Corp Gov TF, Codes etc)			

Direction

	Intv	Doc	Obs
1. Is Auth clear about purpose/role; review its style of working ?			
2. Mission statement and values ?			
3. What is/are the key strategic issue(s) ?			
4. Is there systematic member involvement ?			
5. Is the Auth agenda shaped by Centre or Locality ?			
6 Other			

Executive Management

	Intv	Doc	Obs
1. Chair/CEO boundary ?			
2. Placing items on the board agenda ?			
3. Decision making styles ?			
4. Type of member contribution ?			
5. Who makes the majority of decisions ?			
6. What of executive corporate role ?			
7. Other			

Accountability

	Intv	Doc	Obs
1. Mission statement and accountability ?			
2. Nature of Authority meetings ?			
3. Annual Report ?			
4. Statements ?			
* public			
* providers			
* employees			
* NHS bodies			
5. Other			

Supervision

		Intv	Doc	Obs
1.	Company Secretary ?			
2.	Committees ?			
3.	Information/monitoring/strategic control ?			
4.	Boardroom atmosphere ?			
5.	Agenda items ?			
6.	Implementation ?			
7.	Informal interaction ?			
8.	Review of NEDs ?			
9.	Review of executives ?			
10.	Ethics (posture, code, conflict of interest)			
11.	Other			

	Intv	Doc	Obs
Key Influences			
1. Stat obligations and legal responsibilities ?			
2. Induction ?			
3. Significant influence ?			
4. Informal interaction ?			
5. Relationships ?			
Other			

Appendix 4

Case Study

Observation Schedule

Case Studies
Authority Meeting Schedule

Date:	Authority:
Dimension	Notes/Comments
Start Time	
Finish Time	
Number of: Executives Non Executives Public Press Others:	
Seating arrangements:	
Feel of meeting	
Mood of meeting	
Interaction	
Other:	
Notes:	

Business Schedule

Item	Notes/Comments

Appendix 5

Harrison J J H (19??)
NHS Corporate Governance - Myth or Reality ?

in

M Malek (Ed)
Setting Priorities in Health Care

Chichester, John Wiley