Guardians of public interest: the expectation and experience of non-executive directors in National Health Service commissioning boards in England

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ABSTRACT

Purpose: The purpose of the study is to examine how Non -Executive Directors (NEDs) in the English National Health Service (NHS) commissioning bodies experienced their role and contribution to governance.

Design/Methodology/Approach: Semi-structured interviews were conducted with a purposive sample of 31 NEDs of Primary Care Trusts (PCTs) and 8 Clinical Commissioning Group (CCG) NEDs. Framework analysis was applied using a conceptualisation of governance developed by Newman, which has four models of governance; the hierarchy, self-governance, open systems and rational goal model.

Findings: NEDs saw themselves as guardians of the public interest. NEDs' power is a product of the explicit levers set out in the constitution of the board, but also how they choose to use their knowledge and expertise to influence decisions for, as they see it, the public good. They contribute to governance by holding to account executive and professional colleagues, acting largely within the rational goal model. CCG NEDs felt less powerful than in those in PCTs, operating largely in conformance and local representational roles, even though government policy appears to be moving towards a more networked, open systems model.

Originality/value: This is the first in depth study of NEDs in English NHS local commissioning bodies. It is of value in helping to inform how the NED role could be enhanced to make a wider contribution to healthcare leadership as new systems are established in the UK and beyond.

Keywords: Board governance, healthcare boards, non-executive director, health service commissioning

Research Paper

Introduction

Lay membership involvement in healthcare boards is relevant to public policies of governance derived from the for-profit sector. This research study examines how the lay role is influenced by private sector corporate governance practices and external influences derived from national policy. The findings are relevant to UK and similar healthcare systems globally, and contribute to research on factors influencing healthcare governance. The uniqueness of this study is that it focuses on commissioning organisations rather than healthcare providers.

Our approach is to examine via in-depth interviews the experiences and contribution to governance of the lay Non-Executive Director (NED) on National Health Service (NHS) boards in two successive commissioning organisations (2002 – 2013 and then 2013 – 2018). We present findings on the NED role, contribution and their power within the board, considering how this might be influenced by board structure and external policy drivers. Our study consists of two samples; lay members who had served on the first type of board, and a second smaller sample who experienced being a lay member on both types on boards. This enables a unique comparative analysis and further reflection on the enactment of corporate governance models in the context of changing national policies. External influences on healthcare board governance have been identified as areas for further research (Brown *et al.,* 2018) and this study utilises a model by Newman (2001) to consider how different models of governance, such as markets or networks, influence internal governance roles.

The two English commissioning organizations considered in this study are firstly Primary Care Trusts (PCTs) and then following the Health and Social Care Act (2012), Clinical Commissioning Groups (CCGs) from 2013. These organisations are responsible for the majority of the NHS annual budget in England and commission healthcare services to meet the needs of their local population. Commissioning is a term used in the English NHS to refer to a proactive and strategic process for the planning, purchasing and contracting of health services (Smith and Woodin, 2011).

The commissioning functions for CCGs initially were similar to the local services commissioned by PCTs (i.e. general hospital, mental health and local community services). However, they acquired the function of commissioning General Practice (GP) services after a short period, which accentuated the requirement for lay oversight of potential conflicts of interest which might arise due to the GP doctors on the board both acting as commissioners but also providing services in the community, which might attract additional payment.

PCTs operated on a governance model of a majority of part-time NEDs serving with Executive Directors on a unitary board, that is, with both executive and non-executive members, and headed by a NED Chair (Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations, 2000). When CCGs were established in 2013, the Department of Health in England determined that CCGs were free to develop their own arrangement with minimal specification in the legal framework (NHS Clinical Commissioners, 2015).

CCGs operate as membership bodies with elected doctors representing General Practice. The constitution gives particular weight to these practice nominees, giving more influence to the local GP practice stakeholders than in the predecessor organisations. Clinical stakeholders also include an external medical adviser and a nursing adviser employed part time but mainly employed in NHS provider organizations outside the CCG area, along with a GP practice manager representative and the executives. A sub-set of the members including most NEDs have voting rights (NHS England, 2018). NEDs are a minority on the board, with a minimum requirement for a NED to chair the audit committee and a NED to lead on Public and Patient Involvement. Initially some had a Lay Chair, but the model soon moved in CCGs to having a Clinical Chair and lay vice chair.

Of interest for this study is how the non-executive role might have changed with the move to CCGs, not only due to differing structures but also in response to different models of governance introduced by the government to the public sector, in particular, New Public Management (NPM).

Influence of New Public Management

The role of the board in healthcare organisations has been shaped by its import from the private sector, as part of a range of corporate governance practices introduced in the 1980s. The corporate board's main role is to ensure the managers serve the shareholders' interest: The equivalent for public bodies is to service the interests of the state. NEDs are appointed to provide independent judgement and external perspective, sharing equally with executive directors the responsibility of the board to set strategy and provide accountability, ensuring the organization works in the best interests of its key stakeholders.

The NPM reforms emphasised organisational efficiency and private-sector practices. Strong centralised control was accompanied by a move to decentralise the provision of services, with the role of government seen as shifting from the running of public services to setting the goals for organisations, such as NHS provider organisations (NHS Trusts), and then holding them to account through performance management. However, the policy context for organisations was not that straightforward, as they were also expected to forge partnerships with local communities to shape how services could be commissioned and provided. This could be at odds with the central target-setting and performance management model. Elements of NPM have not always sat easily within the publicly-funded NHS (Ferlie, 2017).

These tensions in governance are captured by Newman (2001) in her dynamic model of governance under the New Labour government. She identifies four different models of governance – the hierarchy, self-governance, open systems and rational goal model – which are plotted against two axes representing the degree of centralisation/vertical integration or decentralisation/differentiation, and an axis ranging from continuity and order to innovation and change. Each model exerts a pull that exerts pressure on the other models, which are described as the dynamics of change (figure 1) The model by Newman is a dynamic one, and, rather than organisations sitting in any one quadrant, different approaches exert different 'pulls'

on organisations. Newman (2001) sees the mix of approaches utilised by Government as producing significant tensions for public sector organisations.

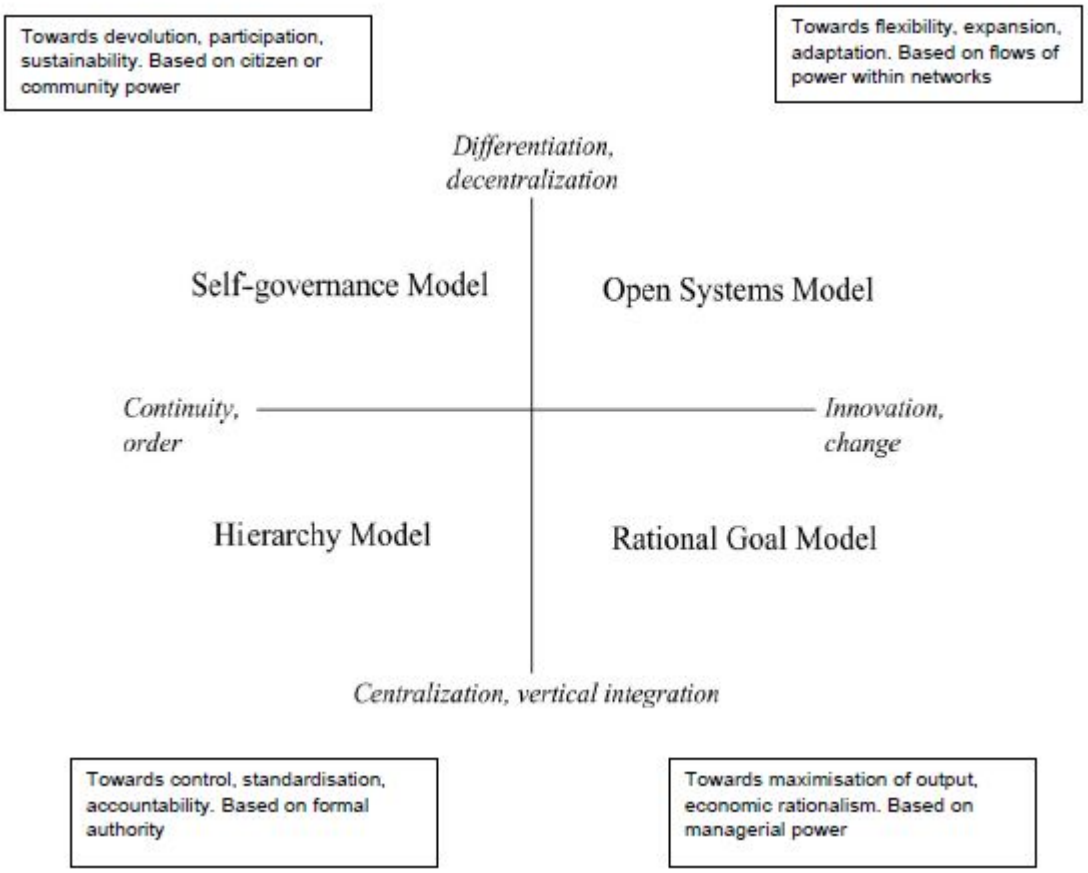

Figure 1: The dynamics of change (Newman, 2001, p.38)

The rational goal model is seen as strong on centralised control (such as centrally-set targets) and geared to efficiency, which it does through marketisation in line with the ethos of NPM. The self-governance model emphasises partnership with citizens, co-production and with greater decentralisation of control. In the early days of PCTs there was an emphasis on working in partnership with others, whether local communities or other organisations in a form of networked governance. These are reflected in the two upper quadrants of the model. One of the limitations of NPM identified by Osborne (2006) is that its intra-organisational focus is limited within a pluralist state, where there are both multiple policymaking processes and multiple actors involved in the delivery of public services. He proposes that new public

governance, which has its roots in network theory, can better reflect this plurality. There has been a growing recognition of other governance trends in the public sector, with consideration of public value, citizen focus and interorganisational collaboration (Osborne and Strokosch, 2013). These trends are variously referred to as public governance or post-NPM approaches.

The Health and Social Care Act 2013 in England seemed to mark an end to a post-NPM emphasis on collaboration or networks, instead emphasising competitive commissioning. However, this has reduced in emphasis in recent years and there has been a renewed call for collaboration, with the creation of Sustainability and Transformation Partnerships in 2016, and Integrated Care Systems in 2018-9. They bring together local NHS organisations and local authorities (county/ unitary local authorities) to develop proposals to improve health by providing better services for patients in the areas they serve. Although Newman (2013) later suggested that network governance was no longer relevant, with the policy emphasis moving away from collaboration, her earlier model appears once more to be a useful lens to help explore the tensions of meeting organisational and national targets, whilst working collaboratively with other organisations on local and longer-term goals. Of interest is how those on the governing bodies, in particular the lay or non-executive member, respond to these different tensions and how they perceive their role in governance.

The role of NEDs in board governance in healthcare organisations

Corporate governance and the development of boards of directors emerged as a response to the growing complexity of commercial and public activity around the world as a result of industrialization. A dominant theory in corporate governance is agency theory, predicated on the need to protect shareholder interests against possible managerial self-interest. The tasks of the board in the private sector have been described by Tricker (2015) as consisting of conformance and of performance roles. The non-executive director, not involved in the day to day running of the organisation, contributes to conformance by providing independent judgement, monitoring executive activity and protecting the interests of shareholders and other parties. Performance-oriented roles include strategic development and contributing wider business knowledge and experience, acting as a source of external

information and connecting the board to useful networks (Tricker, 2015). In the UK Corporate Governance Code (Financial Reporting Council, 2018), the NED is seen as a key part of good corporate governance.

Guidance for public-sector boards has largely followed that in the private sector. A review of how NHS boards contribute to the organisations they lead (National Leadership Council, 2010) found accountability a key theme, where good governance involves assurance that the Board can hold the organization to account as well as being accountable to its stakeholders such as regulators, patients and civic society. Healthcare boards discharge these responsibilities by roles similar to that in the private sector, such as formulating strategy and ensuring systems are in place to monitor and deliver progress against agreed goals.

In all sectors there has been a growing recognition that effective governance in practice involves positive values and behaviours of board members, such as constructive challenge and respect for others. In the public sector there is a particular emphasis on the role of the board in shaping the culture of the organization (National Leadership Council, 2010) and reference to the Nolan principles of public life (Committee on Standards in Public Life,1995).

While the adoption of corporate governance practices based on the private sector precepts and structures into the NHS has been questioned (Chambers *et al.,* 2013), there are only a few studies that explore how managing and governing in the public sector may be fundamentally different (Cornforth, 2003; Chambers *et al.,* 2013). Chambers *et al.* (2013) examine the underpinning theories of the guidance for NHS boards and identify the dominance of agency theory as problematic for health service boards, with its inherent assumption that the board's main role is limited to detecting managerial neglect or malfeasance (p.35), and suggesting that social performance criteria, such as patients' experiences of services are as important as financial ones.

Brown *et al.* (2018) developed a conceptual framework of healthcare governance performance, recognising that there are multiple and multilevel factors that influence and contribute to the governance of healthcare quality. Key input constructs include the knowledge, skills and ability of board members and the influence of the internal and team context. The external environment is highlighted as an influence where investigation in this area has been limited and largely confined to regulation and legislation – a gap this research addresses.

Much of the research on health board governance internationally (e.g Jha and Epstein, 2013; De Regge and Eeckloo, 2020) and in the UK (Endacott *et al.,* 2013; Millar *et al*., 2015; Jones *et al.,* 2017) has focused on the organisations that provide care (hospitals and community services). A focus has been their responsibility for the provision of safe and effective care, with consideration of the board composition and board dynamics that contribute to this. The inclusion of clinicians on the board and their contribution is considered beneficial (Jones *et al.,* 2017), while the NED contribution appears variable (Endacott *et al.,* 2013). An interview study with policy leaders, regulators and patient safety agency leaders found support for a NED role in providing challenge and holding executives to account for governance of clinical quality (Millar *et al*., 2015). This reflects an NPM approach in hospital boards. Consideration of the role of the NED on commissioning boards, with different responsibilities which might call for a different approach, has received far less focus.

One study which included both commissioning and provider boards (Veronesi and Keasey 2010; 2011) investigated a range of NHS organisations to identify if boards were operating to an NPM paradigm, characterised as ensuring efficiency and value for money, or a post-NPM paradigm, characterised by interorganisational collaboration and devolved decision-making power closer to the final user or citizen. NPM principles were still felt to dominate, attributed by the authors to a governance model that stifled dialogue, with financial and clinical expertise allowed to dominate board discussions rather than exploring more collaborative approaches to complex issues. One limitation of this study is that it concentrated more on the provision of care (when PCTs still provided community services) rather than on commissioning.

This NPM emphasis was supported by a study of a range of NHS boards (Storey *et al.,* 2010), which found NEDs brought legal or business skills to the role, with a positive association between PCT NEDs' influence and 'effective use of resources' reflected by an independent measure of organisational performance. However, within CCGs the NED role appears less influential in a more recent study by this team, focused primarily on GP leadership in CCGs, which also included NEDs as respondents (Storey *et al.,* 2015; Marshall *et al.,* 2018). The GPs and Executives were felt to be far more influential on service redesign and communicating with patients and the public than other board members including NEDs.

A study of NHS providers and commissioner (PCT) boards (Sheaff *et al.,* 2015) in England in 2008-9 examined their governance through the lens of the "public firm", where non- executives were increasingly appointed for their non-NHS strategic and governance expertise. This is a NPM approach to recruitment. They found non-executive board members' behaviours in holding the executive team to account at board meetings were variable, and discussion of their role took place in private session. Non-executive directors were most likely to contribute to finance-related discussions but also contributed on broader outcomes such as patient experience and relationships with external stakeholders, indicating a broader, post-NPM approach. The authors note that in depth interviews would be required to ascertain perceptions of how directors conceived their roles.

The role of the NED has been considered as part of studies on the role of health service boards, and very few focused on those with commissioning responsibilities. These studies do not have NEDs as the prime focus. There is gap in research on the role of NEDs in NHS commissioning organisations. This study has wider relevance for the role NEDs undertake in the governance of public-sector healthcare organisations and how this is influenced by models of governance which either encourage an intra-organisational focus and the tenets of NPM, or one oriented towards a more networked, collaborative model of governance.

This study

This study considers the role of the NED from their perspective, examining their role and contribution in two types of commissioning organisations and exploring the influences on the role. The research questions posed are:

1. How did PCT NEDs and CCG lay members perceive their governance role within their organisation?
2. What contribution to governance did they feel able to make?
3. What do these perceived roles and contributions indicate about the influence of different models of governance of these two types of commissioning boards?

Research Methodology

This research had two stages. The first was undertaken between 2011 and 2012, as part of a wider piece of research into the role of NEDs and boards in the NHS. Semi-structured interviews were conducted with a purposive sample of 31 NEDs from 24 different PCTs across England. Chairs of PCT clusters across England were contacted and asked to pass on the invitation to participate in the research. The data sub-set for this study focussed on the role and contribution of the NED and influences on the role. The second stage of the research was to explore the experience of NED lay members (non-clinical) on CCG governing bodies, who had also been on PCT boards, to test out the findings of the earlier research and see if the role differed in the context of the new successor organisations. At the end of 2018 a review was undertaken of all the original respondents to see who had been appointed to a lay role on a CCG governing body and so could provide insights into how the role differed. Only five respondents in this group were identified and they were contacted and invited to take part in this research. Responses were received from three of them. To supplement this an invitation was placed in the bulletin of NHS Clinical Commissioners (a membership body for NHS commissioning organisations) inviting lay members of CCG governing bodies who had also served on PCT boards to be interviewed. This resulted in a further five people coming forward to interview. Although a small number of respondents in the second data set, a strength was gaining the views of those who had served on both types of board. Interviews were conducted by telephone, Skype or face to face. They were recorded

and transcribed, with NVIVO software utilised to aid in data management and analysis. University ethical approval was granted (ETH1718-2376).

Thematic analysis of the data was carried out in line with Braun and Clarke's (2006) approach to thematic analysis. This is described as 'a method for identifying, analysing and reporting patterns (themes) within data' (Braun and Clarke, 2006, p.6). The analytical process consists of 1) Gaining familiarity with the data and generating initial codes, 2) Searching for themes, 3) Reviewing themes. While this might seem like a linear process, the first few stages can be cyclical, with the researcher continually reflecting on the data, the codes being generated, relevant literature and then refining initial codes before 4) Finalising themes. These themes were then mapped across to the model by Newman (2001) to consider how they reflected a rational goal model of governance and NPM principles or a more networked, open-systems one.

Respondents were asked as to their professional backgrounds, as a possible influence on how the role was perceived. These varied, but lean towards the private sector, and included senior positions within the private sector (PCT=7, CCG=2); accountant (PCT=5, CCG=4) academic (PCT=4), Local Authority (PCT=4), NHS, retired (PCT=3, CCG=1) and "other", including the voluntary sector (PCT=8, CCG=1)

Results

The key themes identified relate to how the role was perceived, governance tasks, and NED influence within the board. These results were then considered to identify what they revealed about influences on the role, both from differing internal governance arrangements and also external governance models.

Purpose of NED role

Within PCTs, half of those NEDs interviewed (all from business backgrounds) saw their role was to contribute their professional knowledge and skills to improve organisational efficiency and effectiveness through an emphasis on functions of

finance, corporate governance and administration. This would reflect NPM principles and a rational-goal model of governance. The other group of NEDs came from a wider range of backgrounds, including the voluntary sector. They saw their accountability being to their local community and to patients, rather than the broader tax-paying public, reflecting a more decentralised model closer to local communities. Within CCGs one of the lay roles is clearly defined as representing patient and public interests, and there were two in this sample, and six in a finance/audit role.

These two different types of accountabilities, to the wider public or the local community are explored in more detail below.

Public stewardship

This group of PCT NEDs saw their role as being to promote and protect the stewardship of public resources, as in this example from an audit committee chair:

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

Within CCGs the emphasis shifted from promoting efficiency and effectiveness for public money by challenging and holding to account managers within the organisation, to one where it was clinician self-interest that needed to be kept in check. Within CCG NEDs had a specific role in managing conflicts of interest where GP practices might gain financially by the decisions of the governing body:

> *And then there's the sort of governance aspects of [the role] because the conflicts of interest are just so much greater. And protecting them from their own folly [...] I think they (GPs) intuitively understand conflicts of interests […] but actually sometimes they really need extra protection, you know. So, I think that's my big role.* CCGNED 7

These issues were foreseen by PCTs' NEDs who were in the transitional phase as shadow CCG governing bodies were established. Speaking in 2012 one NED observed of the shadow CCG board:

> *… they are somewhat inexperienced still so […] and they don't really understand issues like conflicts of interest which they need to get to grips with before they take over as a proper consortium, this is GPs […]we are acting as […] a steadying hand really to make sure they don't go off the rails.* PCTNED 9

The potential conflict of clinician interest as commissioner but also a provider of care, had been less in PCTs where the board had ultimate responsibility and a lay majority. However, within CCGs, this area of 'conflict of interests' amongst board members became a major role for lay members and the area where they were provided with the most training.

Representing patient and local community interests

There was a strong focus on organisational efficiency, and a more networked approach and local accountability was also revealed in the data. For some, living in the area served by the PCT or CCG was an important source of information and influence:

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

> *I think it's essential that people can speak from local knowledge, particularly as again we've got the same position where a lot, very few staff live in [x], […] none of the senior staff.* CCGNED 2

For one respondent, comparing her experience on a PCT and CCG, the latter organisation she found more enabling:

> *But in my very small local experience I think actually in the CCG, the patient*

engagement was actually much better through the CCG. And that's not due to my role. It's just due to having structures which are much closer to the ground really. CCGNED 4

At their inception there were more CCG organisations than there had been of PCTs and so CCGs were generally smaller in size. The respondent referred to above was appointed as the lay governing body lead for patient and public involvement and whereas NEDs within PCTs were expected to be 'non-operational', within each CCGS a NED was expected to take on a more 'hands on' role for ensuring community engagement and local accountability:

On the CCG board you're effectively remunerated to work, and to take on responsibilities. CCGNED2

Several CCG NEDs commented how this differed from the PCT board, where the managers would have been held to account for the delivery of strategy, such as public engagement. It indicates a shift away from a private-sector understanding of the NED role in corporate governance.

Role Tasks

Conformance

The conformance aspects of the role – where NEDs monitor executive activity and ensure that all types of performance goals are met – appears to have shifted in emphasis with the move to CCGs. Within PCTs NEDs were able to give a range of examples where they drew on their financial knowledge to highlight risks and persuade executives to modify proposals:

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

Within CCGs finance appeared less of a feature within NED roles. Key governance concerns at the time of interviews in 2018 were the moves to integrated care systems across commissioners and providers:

> *Yes, I think one of the things we need to do when we start having these joint committees, is to then say […], well how does this work, how is this going to work?* CCGNED 8

Performance

The performance role of the board involves a longer-term focus on goals and developing strategic direction. While national priorities may have dominated, such as access to primary and secondary care within prescribed time frames, within PCTs there was still some scope for NEDs to influence strategic plans and ensure they reflected the needs of local patients.

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

However, within CCGs it appears that this strategic role had moved recently to the newly formed partnership structures and that the lay voice had diminished:

> *What's happening is that 10 years ago the keyword was competition which is why you had the providers and purchasers split. […] Partnership is the buzzword today [….] Now, one of the things which actually bothers the lay members is the fact that the officers are involved in discussions with other partners, other CCGs, hospital trusts, local authorities, in actually coming up with informal partnership structures […] We are quite concerned that decisions are being made which, as far as I know there are virtually no lay members on any of these kind of pseudo-partnership bodies.* CCGNED *5*

These concerns about the new partnership models were a recurring theme in the CCG interviews. Within the predecessor organisations, NEDs appeared to play influential roles in helping create and maintain partnerships with other stakeholders, such as hospital trusts. However, as CCGs become more networked organisations, NEDs appear to be left behind with their role remaining organisationally focussed, particularly on managing potential conflicts of interest.

Power and influence of NEDs

Both PCTs and CCGs were considered by NEDs to be constrained in their roles as local organisations due to requirements from 'the centre', as it was usually referred to. Within PCTs this was the Strategic Health Authority, and NEDs talked of executive directors having 'two masters'. The first was their direct accountability to the Strategic Health Authority and through to the Department of Health for meeting key performance indicators, such as for surgical waiting times. This relationship had implications for career progression which could be in conflict with the second 'master', the board of the organisation, which might have different priorities. In the case of surgical waiting times, these may have been subordinated to put resources into longer-term plans to improve population health, but which missed meeting short-term targets. For NEDs to have influence in the board, their independent status or possession of relevant knowledge alone was insufficient. The power of the NED was also dependent on their ability and skill in utilising these sources of power to influence executive directors, seeking to create the conditions where executives responded to the challenge set and a positive dynamic was created. The 'ideal' relationship was characterised as one of ensuring mutual trust in a supportive and constructive context, without showing disrespect:

> *I think the executives really listened to what NEDs were saying, took it on board and followed up with action […] in the main there was a very constructive relationship between executives and non-executive directors and a very mature understanding of the importance of constructive challenge.* PCTNED 34

A range of interactions was identified between NEDs and the executive outside of the boardroom. These included formal board seminars or workshops as well as informal meetings between individual NEDs and directors to offer support:

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

Within CCGs NEDs also arranged informal meetings outside of the formal committees:

> *One of the problems is that because we're not involved in the day-to-day activity [….], I have to go in regularly, actually go and have coffee with people and talk to people and actually pick up what's going on.* CCGNED 5

These additional meetings enabled NEDs to support executive directors but were also a means to gain additional information.

CCGs experience the pull towards centralisation just as did PCTs, with reporting requirements to NHS England (the "centre") and the need to meet financial, performance and quality targets. This was felt to have increased in recent years:

> *..the CCGs did appear to have more autonomy in the first two or three years, but gradually because of financial pressures and the need to have influence over [providers] which cover a far wider area than a CCG, we are again heading back to where we were in terms of strategic health authorities. CCGNED 1*

A recurring theme was the constraints on NEDs and the organisation (both PCTs and CCGs) due to working within a system with strong central reporting lines and with approval of major plans required at a regional level as well as by the board.

Within CCGs the lay members are a small minority on the board and there was a perceived lack of power. Reflecting on the differences between the PCT role, where NEDs were in the majority, and the CCG lay role:

> *So the old PCT board as you know it was a business model, the same as the FTs { NHS Foundation Trusts}: half non-execs, half execs, very similar to the business model, FT model. And the papers and the way of doing business was very much in that model. Governing body of course is a completely different kettle of fish […]. You have a very large number of people round the room. The lay members are very much in the minority; there's only three of us. CCGNED3*

> *…we're such a small group that we have to be very raucous and noisy to be heard. It's all on a sheer numbers basis. And in the end we're powerless really. And that's very different from being a [PCT] non-exec, where you were in the majority, and if you really didn't like what was going on you had the Appointments Commission to speak to [….] I think on paper the decision-making powers are no different to that of the PCT. ... So, on a PCT the autonomy was then you were in groups of people with a wide range of competences making those decisions. Here you have a group of people with a limited range of competences making the decisions.* CCGNED 2

All the lay members interviewed were voting members on the CCG board and this was felt to give them some power, even if decisions rarely went to a vote. They referred to the implicit power that having a voting role gave them in the governing body, one not shared by all the executives.

Discussion

This is the first in depth study of NEDs in the commissioning bodies for local health services in the English NHS. It shows how the NED role has changed substantially as the commissioning organisation changed from being an NHS Trust with a board of directors, similar to that within the private sector, to a membership organisation. Given the much smaller proportion of lay members and emphasis on GP leadership, it is unsurprising that CCG NEDs' governance roles are perceived by NEDs with experience of both organisations to be more constrained in CCGs that in PCTs. However, the internal governance arrangements were not the only influence on the role. This study also considers the external governance models, promoted and regulated by Government, which also influence internal governance and the contribution of the NED.

Limitations of this study

The majority of the interviews were carried out by telephone. This can have some limitations such as in missing nuance and visual cues. However, respondents were experienced board members, used to giving their views and the format did not appear to limit their contributions. The number of CCG respondents was far smaller than the original PCT sample, however the original dataset addressed a much wider set of issues not reported here. The dataset addressing the governance issues reported here is similar in scope. The views expressed were very consistent, suggesting saturation was reached on the key themes in both samples. The time period between interviews of 6 years enabled those who had experience of both organisations to make direct comparisons along with views on the changed context in this time. This also has limitations of hindsight bias.

Influences on the NED contribution

National corporate governance approaches have been identified as one of the factors that can influence healthcare governance (Brown *et al.,* 2018). This study adds to that by considering how external governance policies influence how governance is enacted via NEDs, in practice.

This research initially considered PCTs. These organisations were introduced in 2002. At their creation the model of governance appears to be decentralised,

oriented towards the open system, based upon flows of power within networks, and the model of self-governance, based upon citizen or community power (Newman, 2001). Later emphasis on economic rationalisation and performance measurement saw PCTs pulled towards the rational goal model of governance as reflected in our results, based on managerial power, which focused more explicitly on the management of the organisation and particularly financial accountability. The latter proved to be an over-riding concern for respondents throughout. Our results show that some NEDs tried to move PCTs towards an open systems and self-governance model, and closer to local communities, as appears to have been the original intent of PCTs and that were framed in Government policy until 2010. However, accountability mechanisms to stakeholders were weak and the dominant accountability was hierarchical to regional NHS boards and to central government,

During the period of transition between the proposed abolition of PCTs and the setting up of new structures, this study found that the power dynamics shifted. Whilst the 'pull' towards the demands of the rational goal model and accountability remained, with regional bodies being abolished, and "arms-length" bodies put between the NHS and Government, there was also a pull towards accountability to the local community and greater attention to their needs. At that time, when the initial interviews were conducted, the role of the NED as a steward of local interest came to the fore.

When CCGs were set up in 2012 it appears that the original vision for them was that they would be free from the centralised control PCTs experienced and be able to be more responsive and representative of local communities, a role that CCG NEDs in this study espoused. It is interesting that even in the early phase of CCGs, there were signs that the promised autonomy was illusory. A study of CCGs in the period up to their formal authorisation in 2011-2012, (Checkland *et al.,* 2018) found that they did not experience the promised increased autonomy comparative to their predecessor commissioning organisations, PCTs. While given increased autonomy over some resources, they also found themselves required to interact with an increasing number of networks, groups and organisations to achieve their goals. A case study of GP involvement in 6 CCGs in 2014 found a waning of engagement of

GPs in CCGs (Holder *et al.,* 2015) and concern about their conflicts of interest in commissioning GP services. This has created further pressure on NEDs to ensure conformance with good governance, which was reflected in this study and the increased role of NEDs in helping manage conflicts of interest.

The role of the NED in CCGs increasingly reflects an 'agency' relationship within the organisation, which emphasises the protection of interests against possible self-interest. However, whilst agency theory might be a dominant theory within corporate governance, it has limitations in a public setting (Cornforth, 2003; Chambers *et al.,* 2013). Stewardship theory has its roots in psychology and sociology and, in contrast to agency theory, sees that agents (in this case, whether clinicians or managers) can act as stewards, motivated to act for the collective good for the organisation (Davis *et al.,* 1997).

The broad membership of the CCG governing body and the recruitment of NEDs with specific skill sets and experience would appear to initially support a stewardship view of the role, where the NEDs works collaboratively with managerial and clinician colleagues to 'add value'. However, the need to 'manage' possible conflicts of interests has meant that the agency relationship has come to the fore for some NEDs. This is not to downplay the contribution of skills and knowledge, plus the supportive role that NEDs in this study indicated, but rather that if agency concerns dominate, these may limit the contribution NEDs can make to more strategic discussions and supporting partnerships. This study would therefore support the warnings of Chambers *et al. (*2013) that guidance for NHS boards, based on private sector guidance, can be limiting if agency theory is allowed to dominate.

Within both PCTs and CCGs, NEDs in this study appeared motivated to seek out additional information around decisions and build constructive relationships with officers and managers. Sources of information have been identified as an important construct in effective healthcare governance (Brown *et al.,* 2018). Our study adds to this by identifying a motivator that increases the effort norms of board members to both seek out additional information and also to increase their board effectiveness

through the creation and maintenance of constructive relationships with executive officers. This is the identification of the importance of a public-interest commitment, which may be expressed either as a local representative of patient/community interests or a public servant working in the national (tax-payer) interest. Both identifications provide the NED with a motivation to act with an overarching role as a defender of public interests.

The systematic approach to information available to board members was enshrined in good practice guides (Appointments Commission and Dr Foster Intelligence, 2006). However, NEDs in this study said they needed to have the skills and ability to use information to challenge in a way that did not result in an adversarial relationship with executives. The importance of behavioural dynamics was identified by Veronesi and Keasey, (2011) as an important factor in the pursuit of public value and more collaborative governance approaches. However, with NEDs being a small minority in CCG governing bodies it appears that even with their best efforts to have influence, the greater number of clinicians on the board has meant that they had less power than in PCTs, the predecessor organisation.

Conclusions

This study traces and contrasts the perception of roles by NEDs in PCTs and CCGs and shows how their contributions are shaped by the explicit and implicit constraints on their roles, which have become greater under CCGs, resulting in marginalisation. The NED role in commissioning organisations in England has changed over the past two decades, moving from a model of governance where NEDs were able to contribute community knowledge and help develop networks, to a focus on organisational performance, where non-public sector skills and non-NHS knowledge were seen to add value in a transactional environment. Commissioning organisations in England now face new challenges with moves to more integrated working, where a different skill-set is required for collaborative partnership formation. However, the CCG structures with a predominance of executives and clinicians, and NED roles with a conformance perspective on finance and public representation, are seen by NEDs to be insufficient to enable them to make a wider strategic contribution.

During a previous transition between organisations (2012 – 2013) NEDs took on a particular role in protecting patient and public interest, ensuring these were heard and protected during a time of great change. In the current period of change, the creation of larger CCGs and partnership bodies appear to sometimes trump local autonomy. The lay members of CCGs in our study were concerned that they will be side-lined in these moves and managerial power appears to have increased.

This has practical implications for healthcare governance and the contribution of NEDs. The membership body of CCG board members has suggested their role can be enhanced by NED induction, mentoring and networking (NHS Clinical Commissioners, 2016). But this is unlikely to be sufficient, unless there is recognition that NEDs could make a wider contribution to governance. Their contribution could be enhanced by ensuring they are given explicit roles in promoting good governance of strategic partnership structures, including voting places and financial recognition of additional work undertaken. NEDs could again be empowered to act as boundary spanners with local community interests, able to build relationships with key stakeholders (such as local councils, including with councillors).

Newman's model is not concerned with the role of boards in the NHS and indeed her work predates the organisations considered in this study (Newman, 2001). However, her governance model proved useful for this study as it could accommodate both stability and transition. It acknowledges the tensions caused by competing models of governance that were in play and received different emphasis throughout the lifetime of PCTs and the successor CCGs, and the difficulties this presents for boards, with practical implications for other public sector organisations. This study identifies different roles for NEDs and the value of these in helping the organisation respond to external changes that call for more networked or citizen-responsive forms of governance, rather than a narrower organisational focus.

NHS boards have continued to appoint NEDs from the private sector who have the skills they feel will help achieve organisational efficiency, based on their experience within the for-profit sector. However, this study suggests that a particular skill set such as gained in the private sector should not be the only requirement. The identification with public sector values is an important one that increases effort norms, provides a motivation to utilise sources of power and influences NEDs to use

their role as they see necessary to protect or promote the interests of those they feel they represent. This is an important factor that should not be overlooked in NED recruitment and is of relevance to health systems beyond England that have a system of governance that include Board of Directors and NEDs.

The need for further research on the role of NEDs on hospital boards has been noted in a recent international review of hospital governance (De Regge and Eeckloo, 2020), an equally pressing need is to research further the role of the NED in commissioning organisations. We also recommended further research to explore motivating factors for NEDs to serve on healthcare boards and the impact this may have on the effectiveness of the role and accountability.

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