PUBLIC-PRIVATE PARTNERSHIPS, BOUNDARY SPANNERS AND THE BOUNDARY WALL IN THE ENGLISH NATIONAL HEALTH SERVICE

by

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ABSTRACT

This thesis investigates English National Health Service (NHS) organisations partnering with private companies, a form commonly known as a Public-Private Partnership (PPP). It is clear that the hybrid nature of PPPs makes them more complicated and under researched than other types of partnership. This is compounded when NHS organisations are involved as due to their public values, political importance and sheer size, the NHS provides a particularly difficult set of challenges. To achieve partnership success in these circumstances, both structure and agent factors are crucial. Due to the alternative strands of literature that feed the examination of PPPs, they have generally been investigated in silos. To join them together, a framework called the 'boundary wall' was conceptualised that examined both partnership aspects at the same time by recognising the boundaries between organisations had implications for how boundary spanners (managers of the partnership) carry out their roles and activities.

This thesis makes an important original contribution to knowledge in three ways; conceptual, empirical and methodological. As there is no reason why the boundary wall framework is not applicable beyond PPPs, it could have the potential to improve the success rate of all partnerships. An exciting prospect.

DEDICATION

Many people contributed to the successful completion of this dissertation. In particular, I would like to thank my two supervisors, Professor Jon Glasby and Professor Martin Powell, the best double act since Saint & Greavsie. They have been unstinting in their support and reassurance over the past 9 years, and I would not have succeeded without them.

I would like to thank all the people and organisations involved in my research. They were all very accommodating and made the data collection a smooth experience.

I dedicate this thesis to my wife Cathy and our two children, Ewen and Beth. Their encouragement and love made all the difference.

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CHAPTER 1 - INTRODUCTION

This thesis investigates English National Health Service (NHS) organisations partnering with private companies, commonly known as a Public-Private Partnership (PPP). PPPs have become more popular over recent years, particularly in England since the 1980s (Warsen et al., 2018). Advocates argue that PPPs provide significant benefits to the public sector, such as the increased availability of resources, improved value for money and increased efficiency (Fischbacher and Beaumont, 2003). However, their use is contentious, and the hybrid nature of PPPs makes them more complicated and under-researched than partnerships involving only public-public organisations or private-private companies. The complications compound when the NHS is involved as due to its public values, political importance, and sheer size, partnering with NHS organisations provides many challenges. The thesis focuses on the boundaries that separate organisations within a PPP.

Boundary literature is complex and composed of different themes such as boundaries, boundary objects and boundary work. Each is briefly discussed in turn and expanded on in chapter 4.1 using a framework recommended by Carlile (2004). Many researchers from a variety of disciplines such as anthropology, sociology, economics, and political science have looked to define the boundary phenomenon (Paulsen and Hernes, 2003). However, the focus of this thesis is on organisational boundaries which means that organisational theory provides the most pertinent literature. In this thesis, the concept of boundary will be interpreted as demarcating an organisation from its environment. The term boundary object stems from research by Star and Griesemer (1989). They wrote about how scientists at the Museum of Zoology used boundary objects to help develop common meanings to address interpretive differences. More recently, Weick (1995) suggests that human interactions have the power to shape and mould the attitudes and behaviours of other members of the organisations through 'sense' making. Further helpful boundary object research has been pursued by Leigh Star (2010) and Meier (2015). Gieryn (1983) described professionals that continuously revise their boundaries as 'boundary work'. Gieryn (1999) noted that scientists carried out boundary work when defending independence, expanding and reducing group membership. The use of internal healthcare boundaries has attracted much attention from researchers

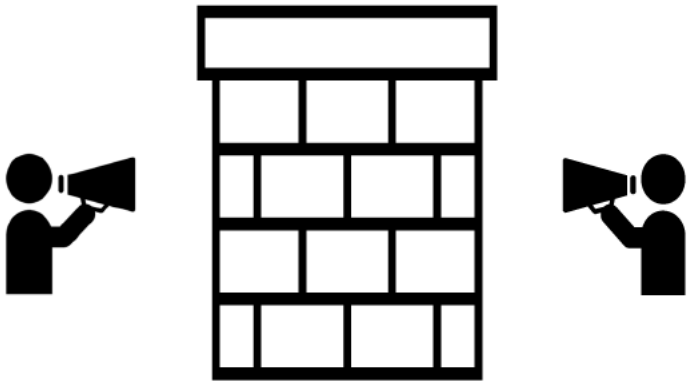
(Fournier, 2002, Sanders and Harrison, 2008, Martin et al., 2009, Powell and Davies, 2012, Chreim et al., 2013, Bucher et al., 2016).

Healthcare research shows that organisational boundaries have an impact that is discreet from the other influences described above (Pugh et al., 2003, Senior et al., 2003, Glickman et al., 2007). In addition, where PPPs are concerned, the thesis contends that it is not only the boundary properties of each organisation that affect the viability of the partnership but also the differences between the boundary characteristics themselves. Therefore, the interaction of the boundary characteristics is framed as a 'boundary wall'.

The ‘boundary wall’ concept is developed to measure and reflect the differences between the organisational boundaries of the PPP organisations. The thesis postulates that the composition and permeability of the boundary wall changes depending on the individual organisational boundaries that make up NHS PPPs. The strength of the boundary wall is dictated by differences in the boundary characteristics of the partner organisations shown in figure 1 below.

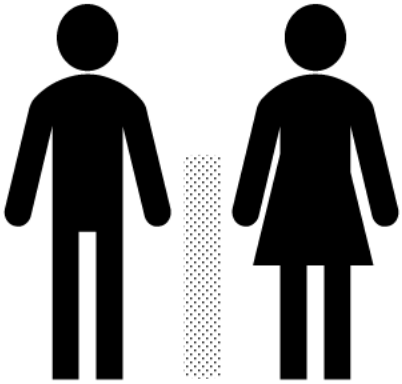
FIGURE 1: THE COMPOSITION OF THE BOUNDARY WALL

This boundary wall is tall, thick, and impenetrable



The strong boundary wall makes it very difficult for communication, collaboration and teamwork to occur in the partnership

This boundary wall is low, thin, and porous



The weak boundary wall makes it easy for communication, collaboration and teamwork to occur in the partnership.

Own Exhibit

With the development of this framework came the additional desire to explore whether these boundary differences impact the roles and behaviours of individuals (boundary spanners) tasked with managing the PPP.

The thesis fieldwork is guided by creating two research questions that first focus on testing the veracity of the boundary wall framework and secondly explore the impact that the boundary wall has on the roles and activities of boundary spanners. The wording of the questions are as follows:

(1) How do the characteristics of the boundary wall change depending on the organisations that make up the NHS PPP?

(2) Does the strength of the boundary wall impact the roles and behaviours of boundary spanners?

They are addressed by using the results from three case studies that constitute the fieldwork. First, the research draws on local documentation, an online partnership survey and semi-structured interviews to explore the composition and permeability of the boundary wall in each case study site. The second question is addressed by analysing boundary spanner and senior managers descriptions of their roles and behaviours of boundary spanners.

This thesis has four main parts split into several chapters: the NHS context and the complexity of PPPs are the focus of chapter 2 and 3; boundaries and the leaders and managers working across them are the focus of chapter 4; developing the boundary wall framework and then its operationalisation is the focus of chapters 5 through 7. Finally, a discussion of the findings is the subject of chapter 8, with conclusions in chapter 9. Each of the main parts of the thesis is summarised in the next section.

1.1 The NHS Context and the Complexity of PPPs

The NHS, created in 1948, covers the whole of the United Kingdom. It is now an umbrella term that includes NHS England, NHS Scotland, NHS Wales, and the affiliated Health and Social Care Board in Northern Ireland. The remainder of the research focuses on private sector involvement within NHS England because politicians introduced several policies that were explicit about developing partnerships between the public and private sectors, which is less accurate of the other three countries – and Scotland in particular actively developed an alternative narrative as to the nature of their reforms and the principles of their system (Evans and Forbes, 2009).

This thesis unravels the complex and intertwined nature of private sector involvement in the NHS from its inception to the present day. It outlines the significant impact the thinking behind New Public Management (NPM) and its descendants have had on NHS reform in England. From the 1970s, the prevailing view of politicians is that the NHS continually needs to be 'reformed' to achieve greater value for money, more consistent quality of care and increased capacity. These reforms initially introduced more 'private sector' management through compulsory competitive tendering and then splitting the NHS into organisations that purchased care and organisations that provided care, which in effect created an internal market. In addition, some of the government NHS reforms actively encouraged private companies to participate in the provision of NHS healthcare.

With the general opening up of NHS services to the private sector, there have been many accusations from politicians and commentators that the NHS is being privatised. For instance, Pollock (2005) notes that it is impossible to divorce the involvement of the private sector from the politics of privatisation. According to Health Minister Simon Burns (2012), opposition to change is part of the NHS's history. As he states:

> 'Stick 'creeping privatisation' and 'NHS' into the Hansard search engine, and you will find over 25 years' worth of parliamentary invective. Almost without exception, every major change to the NHS has been caricatured as a relentless march towards the end of free healthcare'.

In the 2019 general election campaign, the spectre of 'privatisation of the NHS' was raised on numerous occasions by the Labour party in their attacks on the record of the incumbent Conservative Government.

A method that politicians have consistently used to counteract criticisms of NHS privatisation when instigating NHS reform has been to call upon the rhetorical power of describing private sector involvement in terms of 'partnerships'. For instance, this is what the then Secretary of State for Health, Alan Milburn, stated at the launch of the Institute for Public Policy Research (1999) Commission on Public-Private Partnerships:

> 'Let me say at the outset that partnerships between the public and the private sector are a cornerstone of the Government's modernisation programme for

> Britain. They are central to our drive to modernise our key public services. Such partnerships are here, and they are here to stay'.

The emphasis on partnership working was so great that 'partnership' was interpreted as a defining feature of New Labour's administration (Cameron and Lart, 2012). Although over the eight years covered by this thesis, the emphasis on encouraging the NHS to partner with the private sector has taken a back seat with reductions in NHS funding due to the implementation of 'austerity', there are still many examples of new PPPs being created.

In looking to explore the nature of joint working between the public and private sectors, the term 'partnership' is a very slippery concept to define. Indeed, several commentators (Wilson and Charlton, 1997, Glendinning, 2002, Dickinson, 2006) argue that there is no universally accepted definition of partnership. Therefore, it was necessary to look at literature from a variety of disciplines to try to understand what partnership working entails when it comes to the NHS and private companies partnering with each other. The most prevalent themes in the literature (Marsilio et al., 2011) focus on the structure and organisational aspects of PPPs and they can be summarised into four main areas.

The first area reviews the main motivations to partner. The research highlights that there are both organisational and agential drivers for partnerships to form, and it depends on the particular circumstances of each partnership as to which are the most important ones.

The second area reviews the instruments of partnership control that are put in place on partnership formation. These are generally known as governance arrangements. The research looks in detail at the many ways that partnerships can be controlled, with the majority of researchers using the Powell (1990) summary of Market, Hierarchy and Network forms of governance to provide a division between the different arrangements. Network governance, or collaborative governance as some researchers have recently taken to calling it (Ansell and Gash, 2008), is seen as the most beneficial form of governance arrangement for PPPs. There is the assumption that it inspires synergistic gain from sharing resources, risks, and rewards and prioritising collaborative rather than competitive advantage (Huxham, 1996). However, another strand of governance theory emphasises that the differences or

complexity of the organisations involved in the partnership can have a significant impact on how it operates (Glasby, 2003).

The third area raises the important issue that governance arrangements can change as the partnership matures. Research suggests that PPPs may go through several different stages of development and that partnership working may be easier in some of its stages than in others. They also emphasise the dynamic nature of partnerships, reflecting that they have the potential to re-position themselves over time and do not just exist in a static form (Asthana et al., 2002).

The fourth area looks at how PPPs can be categorised. It is deemed necessary as research shows significant variations occurring in PPPs' definition and operationalisation (Gidman et al., 1995, Hodge and Greve, 2005). They observe that the phrase PPP has been used across several families of activities. In some instances, PPPs serve primarily as a basis for risk-sharing and financing public infrastructure projects, and in other instances PPPs involve greater cooperation between public and private organisations in the co-production of services. PPPs that allowed private companies to finance public infrastructure in the UK became commonly known as the Public Finance Initiative (PFI).

1.1.1 Public Finance Initiative

PFI schemes usually involved large-scale constructions such as new schools and hospitals, which the government often funded. Instead, the schemes were put out to tender, and bids were invited from buildings firms and developers who raised capital, built the premises and then leased them back to the Government. The lease arrangements for PFI projects are long term, often 25 years or more and the costs of this borrowing are repaid annually, giving the private sector a profit and the NHS a new hospital (Appleby, 2017). Many commentators, including this researcher, see PFI as a way of using private money to pay for the upfront outlay of the design, build and maintenance and to keep debt off the public balance sheet, rather than establishing a partnership. PFI is a financial and market-based relationship with few if any partnership elements involved. Therefore, PFI contracts between the NHS and private companies were excluded from the analysis. This thesis applies additional descriptors around what it terms a PPP. Taking the suggestion of researchers (Briggs, 2010, Dhillon, 2013), PPPs are conceptualised as a spectrum from weak to

strong forms of partnership depending on the level of strategic involvement of the private sector partner. This thesis fieldwork uses PPPs that reside in different parts of the spectrum.

The literature is clear that the hybrid nature of PPPs makes them more complicated and under-researched than partnerships involving only private companies or public organisations. However, as Friend (2006) points out, there are some essential differences between the two. In the competitive world of business, partnerships tend to be seen as driven primarily by economic assessments of the resources to be contributed by each party, of expected returns on investment, and of associated economic risks. In public partnerships, not only do many of the investments, rewards and risks tend to be downplayed, but the motivations of the partners may become more subtle because of the complex structural mesh that links different levels and areas of public responsibility. In addition, it is impossible to divorce the involvement of the private sector in the NHS from its political implications and the public sector ethos of its staff. These public values combined with strong health service unions have led to NHS staff suspicious of private sector involvement (Gilbert et al., 2014). Coupled with the strong support of the British public, who see the NHS as central to the welfare state, it is clear why creating PPPs in the NHS is a unique and emotive challenge. As Flinders (2005, p. 234) succinctly puts it:

> ‘PPPs challenge central tenets of the British welfare state: a commitment to universal and equal public service, the public service ethos and an implicit rejection of profit-making in certain core public services.’

Therefore, it was not surprising that this thesis found no research that adequately describes and reflects the many tensions created by bringing NHS organisations and private companies together as PPPs. Recognising that the answer to creating effective partnerships might not lie solely at the organisational level, numerous academics (Williams, 2002, Klijn and Teisman, 2003, Noble and Jones, 2006, Long et al., 2013) started to highlight the importance of individual actors in the partnership process.

1.2 Boundaries, Boundary Leadership and Boundary Spanners

Most of the literature on boundaries and boundary work in PPPs defines these actors as the people directly responsible for leading and managing across and within the organisational boundaries.

Within the context of partnership working, leadership has often been viewed as a central way in which diverse partners can be brought together in practice. Encountering a theme that runs throughout this thesis, the research on leadership across organisational boundaries remains under-researched (Vogel and Masal, 2015). Two strands of literature stand out as most relevant and are briefly explored: situational leadership and agent-orientated leadership, and then new trends in partnership leadership are examined. Within the context of partnership working, it is hard not to agree with Dickinson and Carey (2016, p. 30), who state:

> '…the leadership literature has often focused on individuals at the expense of their interaction with followers and organisations, institutions and structures.'

What helped pinpoint more relevant literature was to think about the many differences between organisations in a PPP. Therefore, it is necessary to focus on individuals working across organisational boundaries to broker the many varying relationship dynamics to improve partnership effectiveness. The individuals tasked with this role are often referred to as 'boundary spanners' (Friend et al., 1974, Leifer and Delbecq, 1978, Steadman, 1992, Williams, 2002).

To understand boundary spanners further, the research is interrogated through the lens of the inter-organisational literature, the boundary object literature and the public collaboration literature. Although all three kinds of literature provide valuable contributions, most clarity is obtained through the public collaboration literature and, in particular, the recognition that to manage and facilitate partnership working, boundary spanners perform multiple roles. The work of Williams (2012) is helpful in defining the different roles and behaviours adopted by boundary spanners to make them effective. However, given that insights into the work of boundary spanners are predominantly from public partnerships, it is likely that analysis does not adequately reflect the difficulty of bridging the boundaries created by the public and private organisations within the NHS PPP. This absence is the subject of the next section. In addition, this thesis will investigate the lack of boundary spanner insights from the

PPP literature by seeing if their roles and actions change when confronted by different PPP boundary spanning conundrums.

1.3 Boundary Wall

The extant literature focuses on boundary work activities, and not enough attention is paid to the boundaries they have to bridge. Success depends on both boundary panning activities within the PPP and the nature of the organisations that are partnering. Both are under-researched, so this thesis fills these theoretical holes by creating a new conceptual 'boundary wall' framework. It highlights that when two or more very different organisations partner (as in a PPP), then the organisational boundaries and how they are made permeable must be taken into account when looking to make the partnership a success.

Using insights from systematic reviews of the PPP literature (Marsilio et al., 2011, Roehrich et al., 2014, Bryson et al., 2015, Torchia et al., 2015), as well as incorporating a suggestion from Dowling et al. (2004), who separate 'partnership processes' from 'partnership outcomes' five partnership process themes will be selected for relevance to better define the gap between organisations in the PPP: collaborative processes; conceptualising process success; differential ability to partner; critical success factors and tight/loose partnership arrangements.

TABLE 1: LIST OF PROCESS ORGANISATIONAL THEMES WITH CORRESPONDING STANDARD FEATURES

Organisational Theme	Common Features
Collaborative Processes	• Establish inclusive structures • Trust • Create a unifying vision • Manage power imbalances
Conceptualising Process Success	• Agreement of purpose • Trust • Environment • Adequate management • Accountability arrangements • Cultural fit

Differential Ability to Partner	• Strategic management • Financial/human resources • Technical competencies • Underlying capabilities
Critical Success Factors	• Environment • Membership • Process and structure • Communication • Purpose (shared vision) • Resources
Tight/loose Partnership Arrangements	• Finance and risk-sharing • Strategic planning and design • Resource sharing

Own Exhibit

To help synthesise the standard features of the themes outlined in Table 1 above, the analysis of Huxham et al. (2000) proved helpful. They identify three linked dimensions that represent a broad category of issues relevant to the management of partnerships. These dimensions are: 'managing aims', 'managing culture and language', and 'managing trust and power'. Looking at the individual dimensions, if a universal term is applied to each, it is possible to see related areas in the themes discussed. For example, instead of managing aims, a broader dimension of 'strategy' allows for the tie-up of more standard features from the themes' analysis. Instead of managing culture and language, a dimension of 'culture' provides a more inclusive definition. Finally, the third dimension, managing trust and power, is renamed 'power' because it offers a more realistic managing style for PPPs. Taking inspiration from New Labours analogy of breaking down the 'Berlin Wall' between health and social care (Department of Health, 1998b) , the new 'boundary wall' concept will be created. This concept visualises a wall separating partner organisations, whose composition changes depending on variations in the organisations making up the PPP. Each of the wall properties will be assigned to a dimension: how ‘tall’ the wall is dependent on the strategic fit of the organisations; how ‘thick’ the wall is dependent on the cultural fit between organisations; and how ‘hard’ the wall is dependent on the

power distribution between partnering organisations. This thesis will postulate that the overall strength of the boundary wall directly affects the ability of boundary spanners to perform their primary role in managing the effectiveness of the partnership.

To test the validity of the boundary wall framework, the fieldwork must show that the composition of the wall (which is made up of the difference in the strategic fit of the PPP, the difference in the cultures of the PPP and the power imbalance in the PPP) varies between different partnerships.

1.4 Description of Thesis

Methods

Within the social sciences, research can be conducted in either the positivist or interpretive research paradigm. The research described in this thesis is conducted using the interpretive paradigm with the underlying assumption that the social context of the information situation is interpreted and constructed by people (Williamson et al., 2002). The fieldwork for this thesis consists of three organisational case studies empirically limited to three sectors in one country. The research methods include documentary analysis, a partnership questionnaire and semi-structured interviews.

Findings

The fieldwork quantifies the boundary wall and demonstrates the composition and hence the permeability of the boundary wall changes depending on differences in the NHS PPP organisations. In addition, measuring the individual properties of the boundary wall in each organisation and noting the differences compared to the other organisation (s) in the PPP provides an alternative way of analysing critical processes within each PPP (see chapter 8).

The second research question is addressed by analysing the differences in how each boundary spanner describes their role and behaviour within each case study PPP and seeing how they change. The fieldwork suggests that as the composition and hence the permeability of the boundary wall changes, the roles and behaviours of the boundary spanners change.

Empirical evidence from the case studies indicates that the type of organisation the boundary spanner resides and their work history also impact. It also highlights two additional topics of interest. First, when more than two organisations are involved in a PPP, the thesis recommends that the boundary wall be assessed between all organisations in the PPP because the dynamics between each partner (not just between the public organisation and private company) are likely to impact boundary spanner behaviour and activities. Secondly, the erection of a boundary wall in one public organisation to create an NHS PPP would seem to have a significant impact.

Through the case study fieldwork, some methodological insights were obtained around applying the Partnership Assessment Tool questionnaire and the semi-structured interviews that may be of use to future researchers considering using these tools (see chapter 8.5).

Original Contribution to Knowledge

This thesis makes a substantial original contribution to knowledge in three ways: conceptual, empirical and methodological. The thesis is slightly unusual because the conceptual contribution takes up a significant portion of the whole thesis. This bias reflects the substantial amount of work required to develop a framework that accurately reflects the importance of bridging the boundaries between the organisations within the PPP. The requirement for the thesis to develop a new framework is essential as it highlights two under-researched concepts when applied to PPPs. The first is that the interaction between organisational boundaries within a PPP – the permeability of the boundary wall - differs depending on the nature of the partnering organisations. The second is that this differing permeability impacts the roles and behaviours of employees tasked with managing the PPP. In addition, by measuring the individual properties of the boundary wall in each organisation and noting the differences compared to the other organisation(s) in the PPP, it provides focus and granularity to what are essential partnership performance indicators. Finally, by showing that the roles and behaviours of boundary spanners vary in each PPP, it indicates that the permeability of the boundary wall between the organisations of the PPP does make a difference to how boundary spanners can manage within the partnership.

Second, this thesis provides empirical contributions to the PPP literature. The evidence from the case studies suggests that the type of organisation within which the boundary spanner resides, and its work history impact the way the boundary spanner conducts itself. In addition, these are the first empirical findings to look at the erection of a boundary wall in one organisation to create a PPP and explore the impact of having three organisations participating in the PPP on the behaviour and activities of all the boundary spanners.

Third, this thesis provides methodological contributions to the PPP literature. It suggests that the granularity of the Partnership Assessment Tool questionnaire should be increased. In addition, using the novel idea of two schematics to assess and analyse the content of the semi-structured interviews enables more empirical evidence to be captured.

Practical implications

The permeability of the boundary wall does have an impact on the management performance of boundary spanners. To ensure partnership success, there must not only be sufficient boundary spanning resources to manage the partnership, but additional resources allocated to boundary spanners to bridge the boundary wall. For the larger field of health organisational research, the findings around the erection of a boundary wall in an NHS Trust to create a PPP should encourage future research.

Research limitations

This thesis was limited to three case studies from NHS England. Therefore, although these findings may resonate with all four countries, they are only directly applicable to England. There were many variables that weren't included as part of the thesis such as geographical location, the variability of management teams, the history of the local NHS locale that were not able to be measured but potentially could impact the findings from the case studies. The descriptions used for the boundary spanner roles did not seem to be granular enough to tease out minor differences in the way they performed their management. Not including environmental factors as part of the original boundary wall was a mistake. This was corrected in chapter 7.2.3 where a fourth property of the wall, the foundations was included and then discussed in 8.2.4. There was the limitation of a case study approach discussed in section 6.2.6, and the limitation in the scoring of the Partnership Assessment Tool discussed in 8.6.1.2.

These discussions included the rationale for choosing these approaches and the mitigations employed to reduce these potential limitations.

Structure of thesis

This thesis is organised as follows. It is split into nine chapters, and within each chapter, there are sections and subsections. There is a summary at the end of each section that leads into the next section. At the end of each chapter, there is a drawing out of the implications for the research. Following this introductory chapter, chapter 2 discusses the history and involvement of the private sector within the NHS and how government policy has impacted this over the past thirty years. Chapter 3 explores what 'partnership' means in general before narrowing the focus to Public-Private Partnerships. The research then proceeds in chapter 4 to connect relevant concepts related to the boundaries, boundary work and the management of PPPs by boundary spanners. Chapter 5 looks at various themes that help frame the concept of the boundary wall between organisations implementing an NHS PPP and how it influences boundary panning behaviour. Chapter 6 presents the empirical case of three private organisations working with local NHS organisations before describing the study methods and case studies. Chapter 7 presents the results by providing detailed empirical accounts from each case study through the application of a questionnaire and semi-structured interviews with boundary spanners and senior stakeholders. Finally, the Discussion chapter 8 and Conclusion chapter 9 explore the validity of the boundary wall concept and its effect on the roles of boundary spanners across the three cases and relates these to broader conceptual and policy debates.

CHAPTER 2 - HISTORY OF PRIVATE SECTOR INVOLVEMENT IN THE NHS

The use of the private sector by publicly funded health and social care services is not a new phenomenon, and the NHS has contained some private elements since its inception (Powell and Miller, 2014). Before the NHS arrived in 1948, health care was broadly provided by a mixture of charities and voluntary hospitals and public medical services (funded by subscription), and medical fees paid on an ad hoc basis. Since 1948 a small but significant privately-funded health care system has always existed alongside the NHS, expanding and contracting in line with the country's broader economic state (Greengross et al., 1999). The private sector has always seen itself as complementary to the NHS (Doyle and Bull, 2000). The creation of the NHS meant recognising several types of practitioners as independent contractors such as GPs and most dentists, and hospital consultants were also free to work in the private sector by having part-time contracts with the NHS. However, in more recent times, there has been concern about whether the increasing involvement of the private sector is 'privatising' health care (Pollock, 2005). The researcher will address this concern later in the chapter.

The remainder of the chapter focuses on the evolution of the NHS in England because Scotland, Wales and Northern Ireland have taken different reform paths after devolution. Politicians have developed many policies which are explicit about creating partnerships between public and private sectors, whilst this is less true of the other three countries.

The NHS was organised around a traditional public administration management system, meaning a split between political bureaucracy and professions. The Department of Health was accountable for resources, quality, and service provision (Dalingwater, 2014). However, the 1980s saw the start of an increase in the involvement of the private sector, given impetus with the election of New Labour in 1997.

The increasing popularity of involving the private sector in what was seen as exclusively the work of public sector organisations are generally recognised as applying the concepts espoused by the New Public Management (NPM) paradigm

(Ferlie and Pettigrew, 1996). NPM has framed a significant part of the way public services have consequently been delivered. The following section is therefore devoted to looking at the concept in more detail.

2.1 New Public Management

2.1.1 New Public Management Overview

NPM made the case that, while the commercial sector had undergone radical changes in the 1980s, Peters and Pierre (2000, p. 05) suggest that the public sector remained 'rigid and bureaucratic, expensive and inefficient'. The Organisation for Economic Co-operation and Development OECD (1995, p. 08) observed that a 'new paradigm for public management has emerged, aimed at fostering a performance-orientated culture in a less centralised public sector'. Table 1 below illustrates the main features of the shift from the bureaucratic model of the classical public administration to the new public management, albeit these are two idealised types for ease of comparison.

TABLE *2*: COMPARING PERSPECTIVES: TRADITIONAL PUBLIC ADMINISTRATION AND NEW PUBLIC MANAGEMENT

	Classical Public Administration	New Public Management
Primary theoretical and epistemological foundations	Political theory, social and political commentary augmented by naive social science	Economic theory, more sophisticated dialogue based on positivist social science
Prevailing rationality and associated models of human behaviour	Synoptic rationality, 'administrative man'	Technical and economic rationality, 'economic man', or the self-interested decision maker
Conception of the public interest	Politically defined and expressed in law	Represents the aggregation of individual interests
To whom are public servants responsive?	Clients and constituents	Customers
Role of government	Rowing (designing and implementing policies focusing on a single, politically defined objective)	Steering (acting as a catalyst to unleash market forces)
Mechanisms for achieving policy	Administering programs through existing government agencies	Creating mechanisms and incentive structures to achieve policy objectives through private and non-profit
Approach to accountability	Hierarchical – administrators are responsible to democratically elected political leaders	Market-driven – the accumulation of self-interests will result in outcomes desired by broad groups of citizens (or customers)
Administrative discretion	Limited discretion allowed administrative officials	Wide latitude to meet entrepreneurial goals

Assumed organisational structure	Bureaucratic organisations marked by top-down authority within agencies and control or regulation of clients	Decentralised public organisations with primary control remaining within the agency
Assumed motivational basis of public servants and administrators	Pay and benefits, civil-service protections	Entrepreneurial spirit, ideological desire to reduce the size of government

Adapted from Denhardt and Denhardt (2000, p.554)

In their book *Reinventing Government,* Osborne and Gaebler (1992) argue that if politicians want to transition from bureaucratic to entrepreneurial government, they should make policies and take decisions but do not need to deliver the services themselves. They suggest that governments should steer, but not row. According to Barzelay (1992), a bureaucracy is characterised by centralisation and input orientation, whereas NPM emphasises decentralisation and output orientation.

According to Hood and Dixon (2015), the NPM literature is almost impossible to categorise. However, it has provided researchers with the freedom to hypothesise on a diversity of tools and concepts which comprise a 'shopping basket' for reformers of public administration (Pollitt, 1995). For instance, Ferlie (2017) highlights the 'three Ms' of marketisation, managerialisation and performance measurement. Hood (1991) identifies seven doctrinal components of new public management: professionalism in the public sector, exact standards and measures for performance, greater emphasis on output controls, a shift to disaggregation of units in the public sector, greater competition in the public sector, stress on the private-sector style of management practice and stress on greater discipline and parsimony in resource use. All of these components have their roots derived from the private sector.

2.1.2 New Public Management and Economic Theory

As suggested by Hood (1991), NPM is influenced by the assumptions of two different sets of ideas. The first stream of ideas comes from economic theory. Transaction cost theory (Williamson, 1979) and principal-agent theory (Jensen and Meckling, 1979) are organisational perspectives that promotes ideas of contestability, user choice, transparency and incentive structures in administrative reforms. Pollitt (1993) adds monetarism (Friedman and Friedman, 1990) and public-choice theory (Buchanan, 1968) as additional theoretical sources of NPM. Pollitt (1993) emphasises that these theories portray public bureaucracies as inefficient and

budget-maximising. In addition, the growth of government is a threat to the freedom of individuals and a subtle undermining of enterprise and self-reliance of citizens. In particular, public monopoly is assumed to lead to a lack of efficiency and effectiveness because officials have only a small incentive to keep their costs down or innovate service delivery (Boyne et al., 2003).

2.1.3 New Public Management and Scientific Management

The second set of ideas comes from the managerial school of thought and is in the tradition of the scientific management movement. This school created a set of administrative reform doctrines that Pollitt (1993) believes to be rooted in Taylorism. The setting of targets, the development of performance indicators to measure the achievement of those targets, and an explicit result-orientation are features of this business-type managerialism. Rhodes (1998) conceptualised NPM into six key dimensions. The dimensions ‘ marketisation’ and ‘corporate management’ were particularly influential as the Conservative government introduced market-type mechanisms within the public sector from the late 1980s. Ferlie (2002) pointed out that marketisation leads to a growth of quasi-markets that replace the monopolised provision and introduce provider competition through internal markets. The second feature of marketisation is contracting out, which was promoted by introducing Compulsory Competitive Tendering (CCT) and the Best Value regime in the UK local government (Rhodes, 1998). The compulsory competitive tendering regime specified that the contract for public services had to be awarded to the most competitive bid (Exworthy and Halford, 1999).

Adopting corporate management principles has implications in the way that public sector organisations are managed. As shown in table 2, classical public administration is portrayed as encouraging the maintenance of organisations that are inward-looking and which have been designed for and are run in the interests of the professional staff who work in them (Harrison et al., 1992). NPM, on the other hand, favours managers who are customer-focused, entrepreneurial, and accountable for success or failure. In addition, the Public Sector was urged to become more ‘business like' through techniques such as business process reengineering, using the language of business and recruiting non-executive directors from the private sector (Ferlie and Pettigrew, 1996).

2.1.4 New Public Governance

During the early twenty-first century, NPM came under fire for its questionable benefits and practicality of applying private-sector techniques to the public sphere, especially health services. It came to be seen as one-dimensional, ineffective in the management and governance of health services and leading to fragmentation in the delivery of public services (Dalingwater, 2014).

New Labour presented new public governance (NPG) reforms as a modernisation programme bringing a more collaborative approach, joined-up government, network arrangements aimed at a lesser fragmented organisation of public services. Rather than a commitment to the state or the market, what matters is 'what works' (a so-called 'third way'). However, this approach was criticised as being rather eclectic and better at saying what it isn't (not the state and not the market) rather than what it is? In practice, it seems to have continued a trend towards separating the provision of services from the commissioning of services and a mixed economy of care. As Nigel Crisp (2016, p. 268), Chief Executive of the NHS, when a number of these reforms were put in place, describes the mindset that drove the changes:

> 'These social and private franchising models appear to have the potential for wide application. Working locally, linking with communities and community health workers, dealing with the commonest conditions and providing consistency of training, pricing and quality – these approaches address many of the most pressing needs in many countries. They also use the different strengths and skills of the public and private sectors and strike a balance between private income and public benefit'.

This section has outlined the significant impact the NPM concept has had on public sector reforms. Although the move from public administration to new public management to new public governance is often portrayed linearly and as replacing one with the other. However, Exworthy et al. (1999, p. 20) argue that each paradigm has built on the previous one rather than replaced it 'in the manner of geological sedimentation of rock formations'. However, what is not in doubt is that NPM has had a significant impact on the delivery of public services. As Hood and Dixon (2015) argue, England was not just a 'poster child' but the 'vanguard state' of NPM. The following section looks at how this thinking has influenced politicians and civil

servants since 1979, when private sector involvement in the NHS gathered momentum.

2.2 Healthcare Reform Impacting the Private Sector from 1979

2.2.1 Conservative Governments (1979-1997)

According to Ferlie (2016), the NHS was an early site for NPM reforms driven by the Thatcher governments. The 1980 Health Act reduced the size of the local bodies responsible for running the NHS and galvanised the search for efficiencies savings. In addition, the Griffiths Report of 1983 was instrumental in changing the way the NHS was governed. This report, published by Griffiths (1983, p. 12), managing director of Sainsbury's, claimed that:

> 'If Florence Nightingale was carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge'.

Griffiths recommended that NHS hospitals run like private companies collecting performance information and overseen by general management to put quality and customer satisfaction first.

An additional consequence of the Thatcher government adopting the key conceptual planks of NPM was that from the late 1980s, there was a strong push for public sector bodies to concentrate on *what* should be delivered rather than the details of the *how* (Osborne and Gaebler, 1992). For the NHS, one of the key outcomes was separating purchasers' care activities from providers of care introduced in 1991. Up until this point, the NHS was a complex but unified organisation. Its services were controlled centrally; service delivery was organised through regional branches of the central NHS management. Good performance was encouraged through line management which focused on a service ethos grounded in a commitment to prioritising the wellbeing of patients.

In 1990 *The National Health Service and Community Care Act* (Department of Health, 1990) introduced the purchaser/provider split and an 'internal market' in which the 'providers' - the hospitals and community health services became 'trusts', operating under non-enforceable contracts with local 'purchasers' - the health authorities and some GPs. This approach was broadly consistent with the international trend towards introducing competition into health care systems, which

was widely viewed as the device that would help contain health care spending (Freeman and Moran, 2000). The Act defined the process of purchasing this healthcare as commissioning. It created two commissioning models - one based on health authorities and the other based on general practice. Under GP fundholding, GPs held real budgets. They purchased non-urgent elective and community care for patients; they could keep any savings and had the freedom to deliver new services. The goal was to give GPs a financial incentive to manage costs and apply competitive pressure to hospital providers. Some GP practices came together in consortia, creating larger organisations to pool financial risk and share resources. From 1994 the Total Purchasing Pilot (TPP) scheme allowed general practices to commission all services for their patients -either individually or in groups. However, most were highly selective in what they chose to purchase. TPPs acted as sub-committees of health authorities and used an indicative, rather than an actual, budget.

The same Act introduced similar changes in adult social care, with social workers becoming ‘care managers’ who would design and cost ‘packages of care’ from a mix of public, private and voluntary providers. While funding was transferred to local government for its new responsibilities, 85% of this had to be spent in the independent sector – a stipulation which would be unimaginable in the NHS

2.2.2 New Labour Governments (1997 – 2010)

The move to an internal market policy received increased momentum with the election of a Labour government in 1997, which had significant ambitions in terms of public sector reform. As Tony Blair, leader of the Labour Party (1997, p. 01), claimed in his introduction to the 1997 manifesto:

> ‘In each area of policy, a new and distinctive approach has been mapped out, one that differs from the old left and the Conservative right. This is why New Labour is new’.

These Labour policy reforms outlined in the 1997 white paper (Department of Health, 1997) were seen to be extending the principles of NPM, encapsulated in the notion of the ‘Third Way’ (Giddens, 2013), by trying to remove the binary divide between using either the private sector or the public sector.

As Broadbent et al. (2003, p. 136) note:

> 'This 'Third Way' rejects both the neo-liberal thrust of the previous Conservative government's reliance on the market and the centralised planning and delivery associated with traditional social democracy. In its place is posits an approach that is grounded in the notion of partnership'.

The notion of partnership is constructed on the idea that the private sector can deliver capital projects and services under contract with the state. However, as Alan Milburn, then chief secretary to the Treasury, noted in 2001, the public was not interested in who provided the services; they just wanted them to work effectively and efficiently (Flinders, 2005).

The reforms created some new organisations; Primary Care Groups (PCG) and Primary Care Trusts (PCT) for commissioning services, the Commission for Health Improvement (CHI) and the evidence-based body for the assessment of new treatments, the National Institute of Clinical Excellence (NICE). In addition, hospitals were built with the Private Finance Initiative (PFI), whereby private companies built and operated facilities.

With Labour moving from outright opposition to the purchaser/provider split to a more pragmatic position (Powell, 1999), the NHS underwent multiple reorganisations as the government attempted to refine the way the purchaser/provider concept was enacted in reality. This reflected the increasing tension between competition, commissioning, and quasi-markets on the one hand – and partnership/collaboration on the other. These reorganisations, or as Alan Maynard (2005) sarcastically renamed 'redisorganisations', are outlined in the table below.

TABLE 3: NHS PURCHASER-PROVIDER SPLIT 1991 ONWARDS

Period	Purchasers	Secondary care providers	Choice of provider exercised by
1991-98	192 District Health Authorities (100 Health Authorities from 1996) and GP Fundholders	NHS Trusts (becoming independent from District Health Authorities in a series of waves during 1991-6)	District Health Authorities (Health Authorities from 1996) and GP Fundholders
1998-2002	100 Health Authorities (in conjunction with 481 Primary Care Groups from 1999, descending in a series of waves, with some mergers, into 303	NHS Trusts	Health Authorities

	Primary Care Trusts by 2002)		
2002-06	303 Primary Care Trusts (in conjunction with Practice-Based Commissioners from 2005)	NHS Trusts and NHS Foundation Trusts (descending from NHS Trusts in a series of waves from 2004)	Primary Care Trusts (with Practice-based Commissioners from 2005)
2006 to 2010	152 PCTs in conjunction with Practice-Based Commissioners	NHS Trusts, NHS Foundation Trusts and private sector providers on local menus (also on Extended Choice Network from 2007, then "any willing provider" from 2008 - qualified in 2009 by the Secretary of State declaring that the NHS itself is the "preferred provider" of NHS services)	Patients through Choose and Book (initially from local menus; also from Extended Choice Network from 2007; then based on "free choice" from 2008), Primary Care Trusts with Practice-based Commissioners
2012 Onwards	211 Clinical Commissioning Groups (shadow form until April 2013). Mergers occurring between groups from 2015	149 Foundation Trusts and 93 non-foundation Trusts	Split between national specialist commissioning, and more local commissioning (supported by Commissioning Support Units)

Adapted from the Fourth Report Health Committee (2010, p.10)

In 2000, the Labour government published the *NHS Plan: A plan for investment, a plan for reform* (Department of Health, 2000). It combined a commitment to substantial investment with some quite radical changes. The most controversial aspect of the plan was the introduction of more private sector providers and a more competitive internal market. In addition, the NHS was encouraged to work more closely with local government to tackle what Health Secretary Frank Dobson saw as the ‘Berlin Wall’ (Department of Health, 1998b) between health and social services.

The *NHS Plan* (2000, p. 96) explicitly renounced the ‘standoff’ between the NHS and private health care providers, which existed until then. ‘This has to end,’ it said, ‘ideological boundaries or institutional barriers should not stand in the way of better health care for patients ...the private and voluntary sectors have a role to play in ensuring that NHS patients get the full benefit from this extra investment’. As a result, a concordat was signed between the NHS and private and voluntary providers in October 2000. This allowed NHS commissioners to contract private sector providers to deliver NHS services. The impetus to contracting out came from some related policy initiatives. First, in October 2002, The DH published *Reforming NHS Financial Flows* (Department of Health, 2002), which outlined the development of

Payment by Results (PbR), enabling private contractors to be reimbursed at NHS tariff prices. PbR began in a small way, with national tariffs for 15 Healthcare Resource Groups (HRG) in 2003/04 and 48 HRGs in 2004/05. Next came the introduction of patient choice, which started in 2002 with a pilot scheme that meant patients with coronary disease were offered faster care from alternative providers. This was expanded in 2003 when all NHS patients likely to wait more than six months for inpatient treatment were offered a choice of quicker treatment at an alternative provider. At the same time, the setting up of Independent Sector Treatment Centres (ISTC) paved the way for further private sector involvement.

ISTCs are private-sector owned treatment centres contracted within the NHS to treat NHS patients free at the point of use. ISTCs are often co-located with NHS hospitals. They perform non-emergency procedures and tests. Typically, they undertake 'bulk' surgery such as hip replacements or MRI scans rather than more complex operations.

The NHS Plan originally conceived of opening eight treatment centres by 2005, but by August 2005, twenty-five had been opened. An additional ten were opened in 2007 under the second wave programme. As with many initiatives, the introduction of ISTCs was heavily criticised by some parts of the media (Player and Leys, 2008). Chard et al. (2011, p. 343) concluded in a British Medical Journal article:

> ‘Patients undergoing surgery in ISTCs were slightly healthier and had less severe conditions than those undergoing surgery in NHS providers. Some outcomes were better in ISTCs, but differences were small compared with the impact ISTCs could have on the provision of elective services’.

In addition, there is a wide range of organisations that effectively sit between the public and private sectors – for example, universities and housing associations are private organisations, but their dependence on government funds means that their freedom of action is restricted. Foundation Trusts (FT) are part of the public sector but have varying degrees of freedom.

Foundation Trusts

In 2004 the government introduced a significant new policy strand by creating FTs. These have been an ongoing central part of the government's NHS reforms in

England since then. They proposed greater autonomy to high performing NHS Trusts. FTs have grown steadily, reaching 131 in September 2010, over 50% of eligible trusts. However, this growth has stalled since then, and it is now officially admitted that several Trusts will never reach FT status. The NHS Trust Development Authority was established by the Health and Social Care Act 2012 to supervise Trusts which have not reached Foundation status, of which there were 99 in April 2013. As of July 14th 2017, there were still only 147 FTs out of a total of 216 NHS Trusts. Exworthy et al. (2011) argue that the ability of FTs to exercise autonomy is in place, but the limited extent of implementation may be explained by trusts' lack of willingness to exercise such independence. Such unwillingness maybe because of continued centralisation, unclear policy and financial regimes, fear of negative impacts on relations with other local organisations, and awareness of greater risk to the FT. The early FTs were generally financially buoyant, but more faced financial difficulties during 2013 and 2014, and with continuing austerity, these difficulties intensified. By 2016 the distinction between FTs and other NHS Trusts was widely regarded as eroded. The two separate regulators were combined into a new body called NHS Improvement. The widespread financial crisis undermined the supposed autonomy of FTs when almost all had to rely on money borrowed from the DH to which strings were attached. Despite these setbacks, FTs enjoy more freedoms to be innovative and entrepreneurial, and they are one of the significant ways private organisations engage with the NHS today. The researcher will consider this aspect in greater depth in the discussion chapter.

In 2005/06, the Extended Choice Network (ECN) was introduced, expanding patient choice to include a range of independent sector providers (i.e. private and voluntary hospital providers). This was closely followed by the ‘Any Willing Provider’ (AWP) initiative in 2008/09 and ‘Any Qualified Provider’ (AQP) in 2011/12. Another dimension to patient choice was the implementation of personal budgets in social care and the three-year pilot programme as of 2009.

2.2.3 Coalition and Conservative Governments (2010 onwards)

After the 2010 Election, the Conservatives formed a Coalition Government with the Liberal Democrats, and David Cameron became Prime Minister. NHS spending was relatively protected within a broad theme of austerity. The Conservatives had a slight majority after the 2015 Election. However, Cameron resigned after the 'Brexit'

decision for the UK to leave the EU, and new Prime Minister Theresa May called an Election in 2017, which resulted in a minority Conservative government.

The Health and Social Care Bill 2010/11 was introduced into Parliament on January 19th, 2011. It envisaged shifting many of the responsibilities historically located in the DH to a new, politically independent NHS Commissioning Board, creating a health economic regulator (Monitor) with a mandate to watch for 'anti-competitive practices; and moving all NHS Trusts to autonomous FT status. The White Paper also suggested that SHAs and PCTs were abolished, while integration between NHS and local authority services was strengthened through new Health and Wellbeing Boards. In addition, the voice of patients was to be empowered by establishing a new national body, Health Watch, and local Health Watch organisations. Public Health England, a new body, focused on public health at the national level, and local authorities took the lead locally.

Meanwhile, health care provision was shaken up by competitively driven innovation, with an expectation of easier entry and exit to the market for a range of private and voluntary sector providers. As the scale of these changes became apparent, many commentators, including the King's Fund, expressed concerns about their consequences (Ham et al., 2015). These concerns were put into stark relief by the then Chief Executive of the NHS, David Nicholson, who referred to these reforms as ‘such a big change management, you could probably see it from space’ (Greer et al., 2014, p. 03). A key proposal in the White Paper involved giving responsibility for commissioning healthcare to GPs. This was an odd mix as many (as providers) were private businesses, yet (with a commissioning hat on) were now asked to form public bodies to be stewards of public funding. Of most interest to private providers, it suggested establishing an economic regulator to set prices, promote competition and ensure continuity of essential services.

In June 2011, increasing opposition to the Health and Social Care Bill mainly focused on perceived privatisation of the NHS led the Prime Minister to 'pause' and initiated a 'listening exercise' conducted by the NHS Future Forum, an independent expert group. The Forum recommended wide-ranging modifications to the Bill, which the government accepted. In particular, the change in the remit of the economic regulator from promoting competition to promoting integrated care and tackling anti-

competitive practices was a blow to the private sector looking for easier access to the NHS marketplace.

The *Health and Social Care Act 2012* went firmly down the 'choice and competition' route. It intensified the previous policy of 'any willing provider' (allowing the private sector to compete for NHS contracts). Much of this represented an evolution from Labour rather than revolution, although Health Secretary Andrew Lansley did not frame it in that way. The Act also claimed to move from ‘top down’ bureaucratic process targets to outcome targets that ‘really matter to patients’ (Timmins, 2018).

When Jeremy Hunt replaced Andrew Lansley as Health Secretary in September 2012, he placed significantly less emphasis on the role of competition and choice as drivers of performance improvement in the NHS. In an interview in 2014, Hunt argued that patients were often loyal to local hospitals. In addition, some services, such as emergency care, were natural monopolies where the patient choice would not drive change (Williams, 2014). This changing emphasis was also reflected by the head of NHS England, Simon Stevens, who in 2014 set out a ‘Five Year Forward View’ that stressed integration rather than competition and choice.

Academic Health Science Networks

One of the ways that the private sector now engage with the NHS is through the Academic Health Science Networks (AHSN). These are membership organisations within the NHS in England and were created in May 2013 to bring health services and academic and industry members together. Their stated purpose is to improve patient outcomes and generate economic benefits for the UK by promoting and encouraging innovation in healthcare. Their funding has fluctuated from year to year, and at one stage, it required senior NHS figures to warn NHS England that AHSNs risked slipping into a ‘self-defeating spiral’ after their budget was slashed (Ilman, 2014). However, they survived, and with some judicious marketing and self-promotion, such as producing a yearly AHSN Network Impact Report, they have carved out a role for themselves. In 2019 the 15 regional AHSNs were issued with a new five-year licence to continue their work.

The current coronavirus pandemic, which has put NHS resources under immense strain, has brought the symbiotic nature of private hospital groups and the NHS into sharp relief. Using a report from the King's Fund, Plimmer (2020), writing in the

Financial Times (FT), highlights how the NHS has lost 44 per cent of its general and acute beds between 1987/8 and 2018/9. This figure is caveated by explaining that some reduction is partly due to a shift towards out-of-hospital operations and day-case beds. It is a moot point as to whether the NHS commissioned packets of care increased capacity from private healthcare companies (including some partnerships) or that private healthcare companies stepped into the market vacated by reductions in NHS hospital bed capacity (patients willing to pay to reduce their waiting time). Where there is no doubt is the expansion of private hospital capacity over the past 20 years. On March 21st 2020, the government issued a Press Release (2020) entitled 'NHS strikes major deal to expand hospital capacity to battle coronavirus'. The press release explained the entire capacity of the private hospital sector in England would be used to treat coronavirus patients and take on work the NHS is too busy to carry out. Matthew Hancock, Health and Social Care Secretary, said the independent sector 'will reallocate practically its entire national hospital capacity en bloc to the NHS'. In recognition of the potentially contentious nature of this announcement, he made clear that it would be reimbursed at cost, meaning no profit would be made. David Hare, Chief Executive of the Independent Healthcare Providers Network, said the independent sector stood ready 'to maintain that support for as long as needed'. It will be fascinating to see once the pandemic has receded and the NHS returns to a semblance of normality, whether the wholesale use and the positive response of the independent sector (which has also safeguarded many of their jobs) in a time of national crisis will fundamentally change peoples (including politicians) attitude towards the involvement of the private sector in the NHS.

This section has outlined the impact that healthcare reforms since 1979 have had on the private sector working with the NHS. The following section looks at the arguments surrounding whether the increased role and involvement of the private sector is the NHS's 'privatisation'.

2.3 Privatisation of the NHS?

As with many of the concepts explored in this thesis, the definition of privatisation is contested. Starr (1988) points to the variety of its definition, with privatisation having many unclear meanings. This has allowed commentators to choose an explanation that fits their argument rather than necessarily be entirely accurate. Klein (2013)

believes the concept of ‘privatisation’ is more complex than political stereotypes or rhetoric would suggest and is a ‘malleable’ term.

For Pollock (2005), privatisation is the overarching theme that underpinned the New Labour reforms. Peedell (2011) argues that the government’s health reforms fulfil ‘commonly accepted’ criteria for privatisation. However, as highlighted above, there are no commonly accepted criteria for privatisation. It can equally be argued that using other standard dictionary definitions; the government is not privatising the NHS (Mathieson, 2012). He concludes that accusations of ‘privatisation’ and the ‘spectre of a US-style insurance system’ have become political grenades indiscriminately lobbed at anything that looks like change. The NHS's history is peppered by their deployment, which has become so overused over the past few decades, he believes they have become somewhat meaningless.

When Timmins (2017, p.695) reviewed the increase of private sector provision within the NHS between 2010 and 2015, he noted, ‘if this was the ‘creeping privatisation’ of NHS services, the creeping was still pretty slow’. Powell and Miller (2014) point out that at a broad level, proponents of greater private sector involvement tend to use the ‘minimalist’ dictionary definition of asset transfer in denying they are privatising the NHS. Critics tend to use a 'maximalist' definition regarding any move from public to private as privatisation.

During the 2019 general election, the ‘privatisation of the NHS’ was raised on numerous occasions. For example, during the 2019 manifesto launch Jeremy Corbyn (2019) said:

> ‘Mr Johnson is preparing to sell out our National Health Service for a United States trade deal that will drive up the cost of medicines and lead to the runaway privatisation of our health service’.
>
> ‘£500 million a week of NHS money, enough for 20,000 new nurses, could be handed to big drugs companies as part of a deal now being plotted in secret’.

Boris Johnson (2019) countered this by stating:

> ‘It is completely untrue. There are no circumstances whatever in which this government or any Conservative government will put the NHS on the table in any trade negotiation. Our NHS will never be for sale’.

The fullfact.org (2019) website looked at both claims and confirmed that trade deals don't often seek to redesign public services, how they are funded or who pays for them. US companies now have the right to bid for private English NHS contracts. They say that what is more likely is that the NHS could potentially pay more to purchase drugs from US companies. The US has argued that bargaining on drug prices by organisations such as the NHS means some countries pay less for US pharmaceuticals and says foreign consumers are 'freeloading' at the expense of consumers in the US. It also fits with US priorities from past trade negotiations. However, increased drug prices won't necessarily happen. For example, after Australia negotiated a trade deal with the United States, the gap between the amount Australians and Americans paid for medicines didn't close at all.

Whatever the result of Brexit and the new trade deals that Britain hopes to secure, it is doubtful that the vigorous debate that private sector involvement in the NHS stirs up in academics, commentators and politicians will die down. This debate will be referenced again in chapter 8 when exploring the resistance of unions and local populations to FTs creating wholly-owned subsidiary companies. The following section looks at the nature of the private sector currently operating in the NHS.

2.4 Nature of the Private Sector Currently Operating in the NHS

The role of the private sector in health provision in England is highly varied across primary, secondary and tertiary care and have a range of organisational forms. The general opening up of NHS services to the private sector, due to the reforms outlined in section 2.2, has seen an increase in the value of services outsourced by local commissioning organisations to the private sector. Overall, in the five years to 2013/14, there was a 50% increase in the amount spent by PCTs/CCGs and NHS Trusts on non-NHS providers, increasing the total spend from £6.6 billion to £10 billion (CHPI, 2015). However, to put this into context, it was still less than 10% of the total NHS budget of £113 billion for 2014. This momentum has continued with the private sector being awarded 267 – almost 70% of the 386 clinical contracts tendered in England during 2016/17 showing that private companies continue to make inroads into providing services in the primary care sector (Campbell, 2017). Looking at the secondary care provision, private hospitals in Britain now earn more than a quarter of their revenues from treating NHS patients from less than 10% ten years ago. This

resulted from changes brought in by Labour in 2007 that gave people the right to choose treatment in private hospitals with the state paying. However, as the Financial Times report (Plummer, 2018), in 2018, the £5.78 billion private hospital market felt the effects of NHS cuts and a relaxation of the rules on patient waiting times. The government decided two years ago to remove fines for NHS hospitals that can't treat patients within 18 weeks, and it has cut the number of referrals to the private sector. As a result, NHS hospitals either wait longer before referring patients or take on the work themselves.

TABLE 4: NHS PROVIDER LANDSCAPE AND PRIVATE SECTOR PROVISION

Type of Service	Public Provision	Type of provision by the private sector
Primary care	• NHS primary care trusts (until 2012) • NHS community trusts (since 2012)	• General practice • Dentistry • Optometry • Pharmacy
Secondary care	• NHS acute trusts	• Private hospitals (routine elective) • Independent sector treatment centres
Tertiary and specialist care	• NHS acute trusts	• Specialist care (renal services)
Urgent & Emergency care	• NHS ambulance services • NHS acute trusts	• Urgent care centres
Mental healthcare	• NHS mental health trusts	• Mental health services
Community and social care	• NHS care trusts • Local authorities	• Community and social care services
Pharmaceuticals, devices/Pharmacy	• NHS acute trusts • GP surgeries	• A range of prescription services
Wellbeing and prevention	• Public Health England • NHS care trusts • Local authorities	• Health risk assessments, prevention and rehabilitation services • Exercise, fitness and dietary services • Digital fitness proposition
Diagnostics and scanning services	• NHS acute trusts • Some GP surgeries	• MRI scans • Ultrasound • Pathology testing • Vascular testing
Back office services	• Primary and Secondary care organisations • Commissioning Support Units (CSUs)	• Facilities management • Patient services • IT services

Adapted from NHS Confederation (2015, p. 09)

The NHS Confederation (2015) identifies three themes about how private providers enhance services within the NHS. These are:

- Provide additional capacity
- Deliver an improved patient experience
- Drive innovation

The most significant area where the private sector is seen to add value is increasing capacity in the system. The report highlighted that over 80% of its respondents added value by increasing capacity in the system. This is not surprising as when under capacity pressure, if the NHS uses the private sector, it does not have to commit to additional fixed costs or capital investment to secure such capacity but requests it based on NHS tariff rates. As a result, private sector providers are often better placed to invest in changes that might demand an injection of funds (NHS Confederation, 2015). This explains why there is significant PPP activity around diagnostics and scanning services. There is a requirement for a large initial capital outlay for new scanning technology into hospitals and mobile units.

Promoting an enhanced patient experience has been an aim of successive governments. This has mainly been driven by providing patient choice. However, there has also been an expansion of mechanisms within the NHS to measure a patient's experience of care, including through patient experience surveys, the friends and family test and patient-reported outcome measures. Virgin Care, which operates over 230 NHS and social care services, was the first provider commissioned by the NHS to seek feedback from patients on their care experience.

Although the contribution by the private sector is focused mainly on the current configuration of services and existing models of care, it is still possible for the private sector to drive innovation. For example, independent Vascular Services has invested in information technology that allows scan results to be reported within 10 minutes of examination, supporting more efficient scheduling and diagnosis.

The above section has shown the positive impact that the private sector can make on the efficiency and effectiveness of the NHS. However, critics say the sector's continued success stands in sharp contrast to a long history of winning contracts, only to hand back those that do not yield a profit or have them taken away because of complaints about their service (Campbell, 2017). The following section looks at the history of some of the more recent failures.

2.5 NHS Partnership Failures

The partnership failures can be split into three types of service provision (ambulance services, out-of-hours service outlined in the sub-sections below.

2.5.1 Ambulance Services

2.5.1.1 Coperforma and the Sussex Non-Emergency Transport Contract

This four-year contract for non-emergency patient transport, estimated at £63.5 million, was overseen in 2015 by seven CCGs, run by the High Weald Lewes Havens CCG. Coperforma replaced NHS's South East Coast ambulance service on April 1st, 2016. It was a matter of days before problems with the contract became apparent. In mid-April, the awarding CCGs launched an investigation. In June, the CCGs produced a report criticising Coperforma for unacceptable performance levels, noting patients had problems getting hold of the service and being collected late or, in some cases, not at all. Despite this report and continued complaints, the service failed to improve, and finally, in October 2016, Coperforma were forced to give up the contract. In November 2016, the CCGs announced a transition to the NHS's South Central Ambulance Foundation Trust, with a final takeover in April 2017 (BBC News, 2017).

2.5.1.2 Private Ambulance Service - Bedfordshire and Hertfordshire

Private Ambulance Service, a private ambulance company with 126 vehicles and employing 300 people, were contracted in April 2017 to run non-emergency patient transport from hospitals in Bedfordshire and Hertfordshire. In late September 2017, the company went into administration with trading ceasing October 9th, 2017. Problems had been flagged up about the service, including a report in the Herts Advertiser in July 2017 (Whieldon, 2017) about Herts Valleys CCG issuing an apology after problems with the company's performance, including leaving vulnerable patients stuck in their homes or hospital for many hours.

2.5.1.3 Arriva and North West Ambulances

In September 2015, Arriva over-claimed £1.5 million in bonuses on the three-year contract to run non-emergency transport for NHS patients in Manchester. Arriva erroneously reported its performance to gain the bonus payments. Arriva paid back the bonuses, apologised and pulled out of the tender process to renew the contract (Fitzgerald, 2015).

2.5.2 Out of Hours Services

2.5.2.1 Central Nottinghamshire Clinical Services

In May 2016, Central Nottinghamshire Clinical Services, the private company running out of hours services throughout the East Midlands, said it was filing for administration. It stopped all services in Leicester, Leicestershire, Rutland and North Nottinghamshire, and they were moved to another provider. (Thomas, 2016).

2.5.2.2 Primecare in Kent

In October 2017, Primecare was awarded one of the first integrated NHS 111 and GP out of hours services contracts, confirming that it was handing back the contract to the NHS barely a year through the three-year contract in December 2017. The contract began in late 2016, but after only seven months, Primecare was put in special measures after its provision in East Kent were rated inadequate by the Care Quality Commission. Failings included not assessing patients' health risks and not having enough staff to meet patient needs (Francis, 2017).

2.5.2.3 Serco in Cornwall

From 2006 Serco entered into a contract to provide out-of-hours GP care services for the 500,000 residents of Cornwall. In December 2013, they announced that their contract would end 18 months early in May 2015. The contract had been dogged with controversy. In June 2013, the National Audit Office reported that Serco often failed to meet the national requirements for out-of-hours services set by the Department of Health. They had falsified performance data on 252 separate occasions (O'dowd, 2013).

2.5.3 Hospital Services

2.5.3.1 Tribal Secta and Good Hope Hospital

In 2003 New Labour signed a three-year ‘franchising’ deal allowing a private company, Tribal Secta, to run Birmingham’s Good Hope hospital. The contract was terminated eight months early after the hospital deficit increased from £839,000 to £3.5 million, and the hospital returned to NHS management (BBC News, 2005).

2.5.3.2 Circle and Hinchingbrooke Hospital

Circle, a private healthcare company, was awarded the contract in 2012 to run Hinchingbrooke Hospital. After some initial success around engaging staff by giving

them more say in the running of the hospital and reducing waiting times in accident and emergency, performance, both financially and in the quality of patient care, took a turn for the worse. In January 2015, Circle announced that it was withdrawing from the contract as it was unsustainable in its current form (Melton, 2015). That same day, the Care Quality Commission recommended the Trust should be placed into special measures after it was rated 'inadequate' on whether it was caring, safe and well-led. They expressed concerns about the Trust's leadership because both the Circle management team and the Trust board felt they should hold the Trust's executive team to account. The hospital returned to NHS management on April 1st 2015 (BBC News, 2015).

2.5.3.3 Serco and Braintree Hospital

Serco took over at Braintree Community Hospital in 2011. In December 2013, Serco stated it would pull out its contract early as not enough patients were using the facility. In March 2014, the contract was returned to the Mid Essex Hospital Trust nearly a year early (BBC News, 2014).

2.5.4 Abandoning Procurement

Cambridgeshire and Peterborough Older Peoples Services Contract was an extremely high-profile contract. Its value was worth around £700 to £800 million over five years – for providing older peoples' services for Cambridgeshire and Peterborough CCG. Procuring a provider began in 2013. Initially, some private companies were interested, including Circle, Virgin Care and Capita; however, they withdrew during the process due to the steep financial efficiencies required by the contract. In November 2014, UnitingCare Partnership, a consortium of NHS organisations, was awarded the contract. The contract started in April 2015, but just eight months later, in December 2015, UnitingCare announced that it was returning the agreement as it was not financially viable. The termination of the contract meant around £16 million in unfunded costs for UnitingCare Partnership. These costs were shared between its two trust partners - Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust - as well as the CCG.

In April 2017, CCGs in Staffordshire finally stopped procuring a ten-year contract for cancer and end-of-life services worth £687 million. The whole process began in 2013

and cost the four CCGs over £840,000. The tender was paused in 2015 following the debacle of the UnitingCare Partnership contract in Cambridge and Peterborough. However, after restarting in November 2016, a single bidder emerged, a consortium of Interserve and two hospital trusts. However, Andy Donald, chief officer at Stafford and Cannock Chase CCGs, speaking on behalf of the CCGs, said: 'The remaining bidder couldn't convince us they could deliver with the resources available' (Lintern, 2017).

Another high profile contract abandonment was the West Sussex MSK contract. This £235 million contract for musculoskeletal services in West Sussex with Coastal West Sussex CCG was awarded but never begun once it was determined just how much damage the contract would do to other NHS services in the region. In September 2014, Coastal West Sussex CCG awarded BUPA and a social enterprise called CSH Surrey the contract. However, due to pressure from the public and Western Sussex Hospitals Trust, the CCG employed an auditor to assess the contract's effect on various other local NHS services. The auditors concluded that the impact of the loss of MSK services would mean the Trust potentially falling into deficit over five years. As a result, BUPA and CH Surrey withdrew from the process in January 2015, before signing the final contract (Barnes, 2015).

2.6 Reasons for Partnership Failures

Searching for reasons as to why these and other less high profile NHS/private sector partnerships have floundered, Field and Peck (2004) argue that three main environmental factors should be considered: discontinuity or lack of clarity in policy; discontinuity in organisational structures; and the reliance on non-recurrent funding to support purchasing from the private sector.

2.6.1 Discontinuity or Lack of Clarity in Policy

Section 2.2 has shown that the political environment and policy direction have generally encouraged private sector involvement within the NHS since 1979. The government changes have seen the emphasis change from outright competition between private and NHS organisations for NHS business to a more joint approach in how the private sector contributes to care provision. This tonal change is well illustrated in the Concordat of 2000 (NHS Confederation, 2015, p. 08), which states:

> ‘This is….the start not the end of a more constructive relationship with the independent sector’.

The fact that the policy direction is positive over the highlighted partnership failures makes it unlikely to be a significant contributory reason.

2.6.2 Discontinuity in Organisational Structures

Table 3 in section 2.2.2 amply illustrates the insatiable desire of politicians from all parties to re-organise the NHS. This has meant that some private sector contracts have been negotiated by one NHS organisation which during the contract period has changed into a different one (e.g., PCT changing to a CCG). This is not a unique NHS issue as the private sector frequently undergoes reorganisation due to mergers, acquisitions, or sale. Field and Peck (2004) found that reorganisations appeared to have a limited impact on the relationships between the public and private sectors. Managers from both sectors felt continuity could be maintained at the local level.

2.6.3 Non-Recurrent Funding

Setting up a PPP has financial costs associated with it (see chapter 3). This, combined with the NHS experiencing severe budget constraints, means the current operating reality for the private sector working in the NHS is extremely tough. As the Chief Executive of NHS Providers, Chris Hopson (2017), told BBC Radio 4's The World at One, we are ‘……in the middle of the longest financial squeeze in NHS history’.

Out of the three environmental factors considered, funding was a key contributor to all the partnership failures outlined above. When insufficient money is in the system, issues that could have been managed and services improved by an injection of funds become unsustainable.

2.7 Public Values in the NHS

Researching the type of values contained within the NHS, Merali (2005) concluded that NHS managers generally believed that all NHS workers, themselves included, share altruistic values and demonstrated a collective commitment to the altruistic service ethos of the NHS. These are very different to private sector values. This dichotomy matters; as Marks and Mirvis (1992) point out, if organisations have fundamentally different ways of framing issues and reacting to problems, trying to

bring them together will lead to a 'us versus them' situation. This contrast in values combined with strong health service unions has led to NHS staff being suspicious of private sector involvement (Gilbert et al., 2014). Coupled with the strong support of the British public, who see the NHS as central to the welfare state, it is clear why creating PPPs in the NHS is a unique and emotive challenge.

2.8 Conclusion

This chapter provides a broad-brush account of NPM over the past 30 years and how the paradigm has resulted in politicians introducing healthcare reforms that have significantly impacted how private sector organisations work with and for the NHS. It is a story of significant organisational change. Although governments from both sides of the political spectrum have been in power over this time, the general thrust of healthcare reform has been to see increased private sector involvement in providing services to NHS patients. This has caused a vigorous debate between academics, commentators and politicians, with accusations of ‘privatisation’ being liberally thrown at practically every potential change since 1979. True to form, as the campaigning for the 2019 general election got underway, and the NHS became a primary battleground. The Labour leader at prime ministers questions on October 30th 2019 (BBC News, 2019) stating a Labour government would reverse what he felt was the growing privatisation of the NHS, saying it existed to '……make people better, not make the wealthy few richer’. Taking a dispassionate view of whether the private sector should be providing services for and to the NHS, the analysis in section 2.4 has shown that they can be a positive force by driving innovation, delivering an improved patient experience and providing additional capacity. On the other hand, several high-profile partnership failures have invariably attracted interest in the mass media, raising questions about the involvement of the private sector and the types of vehicle used for that involvement, particularly the suitability of PPPs that involve NHS organisations. To understand the implications of the public and private sectors working in partnership, it is necessary to understand what is meant by ‘partnership’ in general. Therefore, the next chapter reviews the research surrounding partnerships as it applies to NHS PPPs.

CHAPTER 3 - NHS PUBLIC-PRIVATE PARTNERSHIPS

To understand the implications of the NHS and the private sector working in partnership, exploring what is meant by the general term 'partnership' is necessary. Initially, it is sensible to look for an accepted definition of ‘partnership working’. However, this is much harder than it would seem. Even the terminology is subject to varied interpretations and seems to be interchangeable between researchers. As mentioned in chapter one, some commentators even argue that there is no universally accepted definition of partnership. To help in the quest for removing ambiguity around the term, Hill and Lynn (2003) suggest that it is possible to summarise two significant paradigms for defining relations between organisations.

The first paradigm is derived from economics, and the second paradigm is derived from organisational studies. In the case of the former, definitions of partnership usually involve reference to sharing risk. (Williamson, 1979, 1985) one of the key advocates of this approach asserted that, in a true partnership, both players would place a significant proportion of their asset base at risk. In contrast, definitions of partnership derived from organisational studies focus on a range of characteristics habitually used to describe inter-organisational working (Field and Peck, 2003). Within this Inter-Organisational Relations (IOR) literature, there is a multitude of terms to describe partnerships. As Huxham et al. (2000) note, it is often difficult to distinguish 'partnership' from other terms to explain cross-organisational working, such as 'alliance', 'collaboration', 'cooperation', 'networking' and 'joint working'. Hudson et al. (1998) described partnerships according to the degree of integration reflecting networking and the extent of convergence of organisational goals. Ling (2000) compared partnerships according to their membership, the connections between members, the parameters of the partnership and the contextual setting. Peck (2002) considers the balance between the depth and the breadth of the partnership relationship. As seen from the above, a characteristic of the research into partnerships is the wide variety of disciplines, research paradigms, theoretical perspectives and sectoral focuses from which the subject is tackled (Huxham, 2003).

Therefore, it seems sensible that instead of searching for a universal definition of 'partnership', a broader perspective is taken. Several of the most famous theoretical approaches that researchers have called upon to define, analyse and interpret the

actual way in which partnerships form and are implemented are analysed. This is important as researchers focus on different factors that influence an organisation's incentives to engage in independent or partnership production depending on which theory is used (Hill and Lynn, 2003). The chapter will look at some critical features of partnership identified by theories in turn. Section 3.1 reviews why organisations and senior managers might wish to collaborate on joint working rather than stay independent. Section 3.2 reviews partnership governance arrangements, and section 3.3 looks at the types of partnerships created by a public organisation collaborating with other stakeholders. Finally, section 3.4 delves deeper into PPPs and produces a spectrum from weak to strong forms.

3.1 Motivation to Partner

3.1.1 Organisations

When researching why organisations might wish to partner, a helpful summary is provided by Sullivan and Skelcher (2002). They have characterised some theoretical approaches for understanding why partnerships happen by distinguishing between optimist, pessimist and realist approaches.

TABLE 5: OPTIMIST, PESSIMIST AND REALIST APPROACHES TO PARTNERSHIP WORKING

	Optimist	Pessimist	Realist
Why partnership happen?	Resource maximisation	Maintaining or enhancing position	Responding to new environments
Theory	Exchange theory	Resource dependency theory	Evolutionary theory
	Achieving shared vision		
Theory	Collaborative empowerment theory, Regime theory		

Adapted from Sullivan and Skelcher (2002)

The ‘optimist’ perspective assumes that partnerships occur through a desire to achieve a shared vision and is characterised by two key features. First, the partnership will result in positive outcomes for the system as a whole. Second, stakeholders share a level of altruism that mean future positive outcomes for the system override the desire to achieve a more significant gain than the other participating organisations in the partnership.

Exchange theory, developed by Levine and White (1961, p. 588), is an early contribution to understanding partnership working. They state:

> ‘Organisational exchange is any voluntary activity between two organisations which has consequences, actual or anticipated, for the realisation of the respective goals or objectives.

They believe that it is possible, even where scarce resources need to be allocated, for organisations to collaborate altruistically because the goal of system-wide improvement overrides the organisation's desire with the greater power to secure greater security for their position. (this is termed resource-dependency theory which is discussed later in the chapter). While Levine and White (1961) present an optimistic view of partnership, others emphasise the socially desirable outcomes that can be achieved. Himmelman (1996) suggests that the power of partnership rests with its capacity to 'transform' power relationships in society to achieve social justice. He argues that sharing power amongst different stakeholders is the only way to achieve the vision of a fairer society. He terms this power-sharing as collaborative betterment or empowerment and is based on multi-sector involvement. The mutuality that this is based upon implies a degree of altruism among public and private interests as they would be required to give up control and influence to deliver this broader goal.

Finding ways of theorising partnership working between various organisations is also a preoccupation of *regime theorists*. This theory fits with the optimist perspective such as Stoker (1995, p. 55), who says it ‘…directs attention to the conditions under which effective long-term coalitions emerge in order to accomplish public purpose’. Stone (1993), from whose work this theory developed, suggests that government must blend its capacity and resources with other actors. It does this by adopting a new role as mobiliser and co-ordinator and, as in the case of some major cities such as the Liverpool regeneration project after the Toxteth riots of 1981, by building a strategic vision for the urban area in partnership with key actors.

The theorists that expound on the ‘pessimistic’ perspective believe that partnership takes place so that stakeholders may preserve or enhance their power, prioritising personal or organisational gain above all else. This perspective derives from *resource dependence theory* which holds that organisations interact with their

environments and respond to available opportunities and constraints, but strategies are not entirely determined by such external forces (Aldrich and Pfeffer, 1976). Central to the resource dependency view is that each party within the partnership attempts to control or influence the other's activities to the extent of their 'power' within the relationship. As Emerson (1962, p. 32) states, power, therefore, 'resides implicitly in the other's dependency'.

For 'realists', the wider environment is critical in determining the incidence of partnership. In this environment, both altruism and individual gain can coexist. Alter (1993) have developed an *evolutionary theory* of organisational partnership that sets out the realist position. They suggest that partnership working is becoming more likely for a number of reasons, including changing political and economic objectives, growth in technological capacity and increasing demand for quality and diversity in goods and services. As Bryson and Crosby (1992, p. 04) comment:

> 'no one organisation or institution is in a position to find and implement solutions to the problems that confront us in society. In this world, organisations and institutions that share objectives must also partly share resources and authority to achieve goals'.

The evolutionary theory does not assume that partnerships will occur automatically or that they will overcome all barriers. Instead, it highlights the importance of learning as part of the partnership process and again cites this as something that can be beneficial both to the individual organisations and to the broader society (Sullivan and Skelcher, 2002).

Dickinson and Glasby (2010) elaborate on the Sullivan and Skelcher (2002) model by suggesting two additional reasons organisations collaborate. Extending Abrahamson (1991) claim that organisations may merely respond to fashions or fads, they propose the 'pragmatist' and 'mimetist' approaches. The former views partnerships as a helpful tool for publicly justifying more self-interested behaviour and making the resulting changes seem more acceptable. The 'mimetist' approach sees 'partnership' as an automatic response to any given issue - often because local stakeholders feel that is generally expected of them due to political or head office dictates.

Entwistle and Martin (2005) outline three propositions they offer as reasons why organisations decide to partner with each other. The first proposition suggests that in place of control premised on short term, highly detailed contracts, some organisations wanting to partner are interested in cultivating long-term, high-trust relationships. This enables them to understand each other's goals and share information to achieve a synergistic effect. This view has grown out of the *theory of collaborative advantage*, which espoused the notion of synergy, which understands that two or more organisations can achieve more by acting together rather than separately (Huxham and Macdonald, 1992, Huxham, 1993).

The second proposition suggests that some organisations wanting to collaborate are interested in unlocking the distinctive competencies of other sectors. According to the Department of the Environment, Transport and the Regions (DETR, 2001, p. 03): '…strategic partnering can provide access to new skills, resources and ways of doing things and allow for innovation'. By working with business, public organisations can, it claims, access new funds for capital investment; benefit from economies of scale; bring in managerial, technical or professional expertise; develop more flexible approaches to service provision; and share risk (DTLR, 2001, Audit Commission, 2002). The case for partnership working, in summary, rests on private and voluntary sector organisations having abilities, or resources, which are vital to service improvement.

The third proposition suggests that organisations are looking for a partnership to deliver a transformational approach to service improvement. This potential benefit has been directly highlighted and championed by the government. For example, the 1998 White Paper (DETR, 1999, p. 04) explained that Best Value was designed to '…secure improvements in quality as well as in cost'. One only has to see the mimetist approach suggested by Dickinson and Glasby (2010) to understand this type of governmental pressure can be a compelling incentive for public organisations to enter into partnerships.

Hunter et al. (1996) make the important point that the desire to partner can depend on how crucial the supplier's product or service is to the customer. The more important the supply, the more the customer is likely to desire relationships that offer some degree of security in the provision, such as product quality, consistency, and

centrality to the process or safety. Put simply, a long-term partnering relationship is more likely if a supplier is providing a critical raw material or service, the absence of which can disrupt the manufacture of a vital product. At the other extreme, it is relatively unlikely that a customer will seek a close relationship with a supplier whose materials are relatively marginal to company performance or are easy to procure from other organisations (Marchington and Vincent, 2004).

Another way of looking at the many rationales given for wanting to partner is the many diverse narratives or 'stories' created in the literature. O'Flynn (2013) summarises these into six separate ones, as shown in Table 6 below.

TABLE 6: THE SIX NARRATIVES OF PARTNERSHIP CREATION

Story type	Narrative
21st Century modus operandi	Positions partnering as the 'new normal' for governing. In a world confronted by increasing complex challenges and more demanding citizens, the government will need to increasingly collaborate with others to address issues and deliver outcomes.
Coordination	Frames partnering as an a priori response to the perennial problem of coordination. In this sense, the story is nothing new but rather a reiteration of the fundamental question of how to coordinate action and actors
Disaggregation and fragmentation	Positions partnering as a corrective to the intensification of fragmentation and disaggregation associated with new public management era reforms. In this story, the increased demand for partnerships reflects the more complex governing environments
Complexity	Explains the increased need for partnering as a reaction to the increasingly complex challenges that confront governments. Complex societal problems, such as climate change, poverty, global migration, and homelessness, for example, disrespect boundaries. By their very nature, these problems require people to work across boundaries to address them.
Strategic management	Recognises that other parties often hold the capabilities needed to achieve outcomes and, in this case, government does not have a monopoly on these critical resources. Leveraging these capabilities requires a more strategic approach to working across a range of boundaries and the development of different relational architecture
'Better value'	Draws together perspectives which argue that various forms of partnership can produce increased value. This may be through better utilisation of scarce resources (efficiency), reducing contradictions or duplications across government (effectiveness) or improving services for citizens (quality)

Adapted from O'Flynn (2013)

The analysis above has explored why organisations might partner and clearly show that context and specific rationales are important. However, organisations are made up of people (agents) who have different motives and interests as to why they want

to collaborate. This line of research has produced many theories, and the most relevant to this thesis are discussed.

3.1.2 Agency Motivations to Partner

Agency, which in this context involves management and leadership, is possibly some of the most written phenomena of the past fifty years (Dickinson and Carey, 2016). However, the evidence base is far from conclusive (Peck and Dickinson, 2009). Bryson et al. (2006) suggest leadership within partnership formation refers to an identified leader who can initiate and help secure resources for a partnership. The leader should commit to collaborative problem solving, be willing not to advocate for a particular solution, and exhibit impartiality concerning participants' preferences. In addition, the ability of the leader to absorb the high transaction costs of initiating a collaborative effort may help the partnership get off the ground.

In the initial stage of the partnership, Noble and Jones (2006) suggest a clear distinction between the roles of 'project champions' and 'boundary spanners. Project champions are senior management who perform the process of identifying the need to form a PPP. The actions of senior management thereby create the conditions within which boundary spanning managers must subsequently work.

Hill and Lynn (2003) describe two theory classes to help explain the urge for agents to collaborate. The first, *rational choice theories* are concerned with exchanges (e.g., monetary) or other interactions (e.g., information). The second *socialised choice theories* are concerned with relationships other than exchange relationships that might further shared values. In reviewing specific theories in these two classes, Hill and Lynn (2003) show how the approaches focus on different factors that influence an organisation's incentives to engage in independent or collaborative production.

3.1.2.1 Rational Choice Theories

Two assumptions are fundamental to rational choice theories: first, individuals react rationally to changes in which their goals can be fulfilled, and second, the relative values that individuals place on achieving various goals are stable. As Thompson (1967) points out, it is about the predictability with which organisations *transact* business with each other. *The principal-agent theory* involves relationships between those in charge of human service production as 'principals' and the producers as 'agents'. From this perspective, Miller (1993, p. 02) suggests:

> ‘Agents are perceived as having distinct tastes (such as the desire to limit risk-taking or costly effort), which they pursue as rational maximising (actors). The principal's job is to anticipate the rational responses of agents and to design a set of incentives such that the agents find it in their own interests (given the incentive system) to take the best possible set of actions (from the principal’s perspective)’.

Game theory informs how autonomous actors choose whether or not to cooperate and how such choices depend on the structure of their interactions. What participants know about each other and the state of their operating environment are important elements in decision making. Further, dynamic factors can be analysed by viewing collaboration as involving repeated interactions. For instance, a single-stage interaction may result in a Prisoner's Dilemma outcome, but repetition may lead to a cooperative strategy.

3.1.2.2 Socialised Choice Theories

In contrast to rational choice theories, socialised choice theories believe agents may behave by a socially constructed habit or norm without necessarily reflecting on its rationale (Hardin, 1997). This places social structures at the heart of any collaboration and has significant implications for formal and informal governance arrangements. Emerson et al. (2012), aiming to formulate a framework for collaborative governance, highlight several essential drivers without which the push for collaboration would not be successful. These drivers include leadership, consequential incentives, interdependence, and uncertainty.

Consequential incentives are either internal (problems, resource needs, interests, or opportunities) or external (situational or institutional crises, threats or opportunities) drivers for partnership working. Emerson et al. (2012) suggest that such positive or negative incentives must exist to induce leaders and participants to engage together.

Interdependence, or when individuals or organisations cannot accomplish a goal on their own, is a broadly recognised precondition for partnerships (Gray, 1989, Thomson and Perry, 2006).

Uncertainty is a primary challenge for managing ‘wicked’ societal issues (Koppenjan and Klijn, 2004). The uncertainty that cannot be resolved internally can drive leaders to collaborate to reduce, diffuse, and share risk. As Grint (2005, p. 1478) comments:

> '…where no one can be certain about what needs to be done to resolve a Wicked Problem then the more likely decision-makers are to seek a collective response'.

The above section has explored the many and varied potential reasons for organisations to partner. It has highlighted that there are both organisational and agential drivers for partnerships to occur. It depends on the particular circumstances of each partnership as to which are the most important ones. The research emphasises the different roles required of management between setting up and implementing any partnership. This will be referred to again in the next chapter. Once the organisations have decided to collaborate, the next stage is the actual formation of the partnership.

3.2 Partnership Form

Now that two or more organisations have initiated coming together to collaborate, it is helpful to explore how the instruments of partnership control, generally known as the governance arrangements, might affect how the partnership is operated.

Attempts to differentiate modes of governance owe a debt to Williamson (1985) analysis of 'markets' and 'hierarchies' as distinct governance structures associated with particular transaction costs on actors. Subsequent research has added additional categories to Williamson's formulation, the most influential of which uses hierarchies, markets and networks (Thompson et al., 1991). A valuable summary of the difference between the three governance types is provided by Powell (1990), who provides a clear distinction between market, hierarchy, and network, illustrated in table 7 below.

TABLE 7: COMPARING MARKET, HIERARCHY AND NETWORK FORMS OF GOVERNANCE

Key Features	Forms		
	Market	Hierarchy	Network
Normative Basis	Contract - Property Rights	Employment Relationship	Complementary Strengths
Means of Communication	Prices	Routines	Relational
Methods of Conflict Resolution	Haggling - resort to courts for enforcement	Administrative fiat – Supervision	Norm of reciprocity – Reputational
Degree of Flexibility	High	Low	Medium

Amount of Commitment Among the Parties	Low	Medium to High	Medium to High
Tone or Climate	Precision and/or Suspicion	Formal, bureaucratic	Open-ended, mutual benefits
Actor Preferences of Choices	Independent	Dependent	Interdependent
Mixing of Forms	Repeat transactions, Contracts as hierarchical documents	Informal organisation, market-like features: profit centres, transfer pricing	Status Hierarchies, Multiple Partners, Formal rules
Implication for partnership working	Difficult	Possible	Encouraging

Adapted from Powell (1990, p. 300)

3.2.1 Market-Orientated Governance

The general assumption of the market mechanism is that actors base their behaviour on the price within a competitive market and contractual exchange relations based on that price. Consequently, the governance instruments used are often formulated in terms of a *principal-agent* relationship. Although markets provide a high degree of flexibility to actors in determining their willingness to form partnerships, the competitive nature of the environment and the parties' underlying suspicion may limit the degree of commitment to any collaborative adventure. Essentially, actors prefer to be independent and choose to collaborate only when they see particular advantages (Lowndes and Skelcher, 1998). The implication for partnership working is that this type of governance arrangement would work against its smooth running as conflict would most likely end up in court or the partnership breaking up in acrimony.

3.2.2 Hierarchic Governance

Hierarchy entails a number of typical features. First of all, control is top-down. Actors that are being controlled are considered relatively passive objects. Secondly, authority is the interaction pattern. Rules and commands are the basis of planning in a normative power relation, whereas supervision is the basis of management control. In terms of sanctions (positive and negative), rewards and punishment are used. Finally, conflicts are resolved through authority, which the controlling public partner exercises. Such organisational forms have tended to dominate public services.

Partnership working using this type of governance structure is possible. An example of this is outsourcing IT departments to private contractors within the public sector. Detailed input and output specifications are drawn up, and strict sanctions for poor performance are written into the contract by the public partner.

3.2.3 Network/Collaborative Governance

Powell (1990) characterised network forms of organisation as reciprocal patterns of communication and exchange. The basic assumption of the network is that the pooling of resources is an advantage for the involved parties. This is also the position taken by Lowndes and Skelcher (1998, p. 318), drawing on the work of (Kooiman, 1993, Kickert et al., 1997). They state:

> ‘The network mode of governance arises from a view that actors are able to identify complementary interests. The development of interdependent relationships based on trust, loyalty, and reciprocity enables collaborative activity to be developed and maintained. Being voluntary, networks maintain the loyalty of members over the longer term. Conflicts are resolved within the network based on members' reputational concerns’.

Using their analysis, it is possible to define six network governance features. The first feature is that interactions are based on reciprocity. Secondly, the network mechanism is based on the idea that actors can identify complementary interests. This leads to resource exchanges between actors based on interdependent relations, trust, loyalty and reciprocity (Kickert et al., 1997). The third feature is the equal status of the public partner amongst the other actors in the networks. The public partner does not hold a hierarchic position vis-a-vis other actors, in the sense that it cannot force the other actors directly to behave in a certain way. Policy, the fourth feature, is developed jointly in a network by interdependent partners. The fifth feature is that the network mechanism involves a specific set of management strategies in which success is not necessarily measured in terms of goal achievement but also in terms of satisfaction of participants about the process itself and whether joint solutions for problems can be agreed upon (Kickert et al., 1997). Finally, conflicts are typically solved using the reputation of network members rather than sanctions. Partnerships have often been equated with the network form, given the focus on horizontal relationships. With the emphasis on mutual benefits and

working together and informally to solve potential difficulties, this type of governance arrangement is well suited to the stresses and strains of partnership working.

Recognising that organisations within a partnership don't necessarily involve just the public sector, researchers have refined the ideas of network governance when it applies to other types of partnership arrangements as *collaborative governance*. Ansell and Gash (2008, p. 544) define collaborative governance as follows:

> 'A governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-orientated, and deliberative and that aims to make or implement public policy or manage public programs or assets'.

Subsequent researchers such as Emerson et al. (2012) characterise collaborative governance as a system in which *cross-boundary* collaboration occurs, including other types of stakeholder partnership. Crucial to distinguishing collaborative governance from other forms of organising is the emphasis on consensus decision making. It is characterised by a notion of synergistic gain and programme enhancement from sharing resources, risks and rewards and the prioritising of collaborative rather than competitive advantage (Huxham, 1996). It is not a 'winner-take-all' form of interest intermediation. In collaborative governance, partners will often have a contentious relationship, but the goal is to transform negative relationships into more cooperative ones (Ansell and Gash, 2008).

When research has looked at the governance arrangements specifically within PPPs, it shows considerable scope for tension, problems and conflict between partner organisations (Glendinning et al., 2002). One set of research focuses upon the causes and consequences of these tensions. Williamson (1985) and the Transactions Cost Economics theory (TCE) constitutes the most cited theoretical framework for PPP analysis (Marsilio et al., 2011). According to TCE, PPPs are considered a contract acting as an intermediate governance mechanism, called hybrid or relational, between the market (private sector) and the hierarchy (public sector) to reduce the transaction costs of public services. The output and outcome required from these agreements between public and private sectors have characteristically been specified and monitored through detailed contracts.

However, a wide and prominent part of the literature on contractual relations and partnerships contradicts this view, emphasising the role of people within partnerships. This approach has scholars taking more 'agential' aspects of a PPP contract into account (Williams, 2002, Klijn and Teisman, 2003). Accordingly, the functioning of a partnership requires a well-structured contract mechanism aimed at reducing transaction costs and a degree of mutual trust between the parties (especially for long-term partnerships) and the network governance mechanism. From this perspective, PPPs become a new governance paradigm to manage the inter-dependency of public organisations and private companies. A characteristic of the network society is the blurring of the borders between the public and private sectors and the interdependency of these various organisations (Castells, 1996). According to this framework, the mutual adjustment of public and private strategies becomes a fundamental prerequisite for the success of PPPs. This joint adjustment requires the stipulation of a contract and calls for synergy and trust (Kanter, 1994). These agential factors will be explored in more detail in the next chapter.

3.2.4 Governance Complexity

An additional way of viewing how stakeholders organise their collaboration is by exploring the complexity of the partnership. Complexity refers to the level of variety and dependency within the different parts of a partnership. Complexity increases when differences and interdependencies increases (Edmonds, 1995). As Ansell and Gash (2008) point out, the imbalance between the power of stakeholders, the incentives that stakeholders have to collaborate, and the history of conflict or cooperation among stakeholders all have a significant impact. This finding is reinforced by Fincham and Forbes (2015), who highlight the often significant power differences between professionals in different specialities, resulting in higher levels of complexity. Glasby (2003) identified that complexity could be usefully analysed along three dimensions. He presents activity within a partnership in terms of a series of interlocking circles, made up of the individual, organisation and structure. Each level of activity can influence or be reinforced by the other levels. Thus, the way individuals behave is based in part on the norms, values and policies of their organisations, which are shaped by the policy directives of the central government. For instance, prevailing political or organisational fashion may be a significant factor in local partnerships' forms.

3.2.5 Partnership Life Cycle and Governance

Finally, when considering governance arrangements, a number of researchers have emphasised the time element or lifecycle of a partnership. This acknowledges that partnership working may be easier to achieve in some of its stages than in others. Gray (1989) proposes a 3-stage model to define the changing nature of partnerships - problem setting, direction setting and implementation. Other research has captured these dynamics by looking at longitudinal studies of partnerships (Sydow, 2004, Keast and Hampson, 2007, Provan, 2008). Together these studies have demonstrated that partnerships go through several different stages of development that potentially require a different focus and produce different results. It also emphasises the dynamic nature of partnerships, reflecting that they have the potential to re-position themselves over time and do not just exist in a static form (Asthana et al., 2002). Academics suggest there are two aspects to the way a partnership changes over time. The first is the formal mode of governance (Lowndes and Skelcher, 1998), and the second is the relationship between stakeholders (Agranoff and McGuire, 2001). The formal governance arrangements are relevant as they provide grounds for control, but their presence may say little about how the partnership operates daily. A partnership agreement might encompass a comprehensive set of formally stipulated control instruments that are not used in the real-life interactions between the public and private actors. Both must be considered. This idea that the formal mode of governance can be different from how the relationship works on the ground is important and will be returned to in chapter 8.

TABLE 8: STAGES IN THE PARTNERSHIP LIFE CYCLE

Stage in the Life Cycle	Mode of Governance	Relationship between stakeholders
Creation	Hierarchy – Formalisation of authority in partnership board and associated staff	*Activation* – involves identifying the right people and resources for creating the partnership
Consolidation	Hierarchy – Formalisation of authority in partnership board and associated staff	*Framing and Mobilising* – establishing a culture and helping to develop a structure
Delivery	Market - Mechanisms of tendering and contractual agreements AND/OR Network – networking between individuals/organisations to maintain commitment	*Synthesising* – helping to create productive and purposeful interaction between members of the partnership

Adapted from Agranoff and McGuire (2001), Lowndes and Skelcher (1998)

This section has considered the potential ways stakeholders can organise themselves once the partnership has been initiated. Numerous frameworks seek to categorise partnership governance arrangements. This thesis has concentrated on the valuable market/hierarchy/network/ distinction, providing insights into the context in which managers operate and the rules governing activities. It also raises the important issue that governance arrangements can change over time as the partnership matures. Most research in this area has focused on public sector organisations collaborating. However, partnerships also occur between the public and the voluntary sector and between public and private organisations. The following section briefly looks at the history of public/public and public/voluntary partnership partnerships to understand the differences when different organisations enter into a partnership. It uses NHS involvement as the basis for the analysis before focusing on PPPs, the least researched type of partnership.

3.3 Types of Partnership Involving the NHS

3.3.1 Public Sector/Public Sector Partnerships

One of the most complex public/public partnership types is between the NHS and social care organisations (Peck, 2002, Cameron and Lart, 2003, Ball et al., 2010, Cameron and Lart, 2012). Attempts to coordinate health and social care services through national planning systems have gone through three distinct phases. In the late 1960s and during the 1970s ten year plans for hospital and community services were introduced, followed by a similar exercise in the early 1970s for the new Seebohm social services authorities (Wistow, 1990). Hudson (1992) concluded that none of these initiatives amounted to much due to impaired vision, monitoring, and funding.

From the mid-1970s onwards, policies focused less on national planning systems and more on local reorganisation to solve fragmented services. For example, the 1974 reorganisation of the NHS created Area Health Authorities to bring many health services under the same organisational umbrella by moving community health services out of local government and into the NHS (Ottewill and Wall, 1990).

In the second phase, the 1980s and 1990s, the new agenda was about reducing public provision and involving the voluntary and private sectors more fully, thereby maximising the application of resources to health and social care through a 'mixed

economy of provision. Finally, the election of a Labour government in 1997 heralded the third phase. Vital to this was the 1998 Department of Health consultation document looking at future relationships between health and social care. Entitled *Partnership in Action* (Department of Health, 1998b, p. 03), the document proposed various ways of promoting more effective partnerships:

‘All too often when people have complex needs spanning both health and social care, good quality services are sacrificed for sterile arguments about boundaries. When this happens people, often the most vulnerable in our society… and those who care for them find themselves in the no man's land between health and social services. This is not what people want or need. It places the needs of the organisation above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers’ money – it is unacceptable’.

As Peck and Dickinson (2008, p. 15) conclude:

> ‘…partnership working is no longer an option (if it ever was) but a core part of all public services and all public service professions’.

Following a review by Lord Laming (2009) prompted by the tragic deaths of two small children in the Borough of Haringey, national and local policy increasingly emphasised enhanced and more effective partnerships between the NHS and social care as a potential solution. However, it is fascinating to see that even today, the same lack of coordination, integration, and partnership are raised. For instance, if there is no room within local social care facilities, local hospitals cannot discharge patients even though they don't require further hospitalisation. Every extra day a patient who is medically fit is discharged but stays in hospital unnecessarily, it is counted as a lost bed day. Age UK (2019) analysis showed that during the 917 days between the General Election on 8th June 2017 and the General Election on 12th December 2019, lost bed days in the NHS due to diminished social care topped the 2.5 million mark costing the NHS an additional £587 million. Although outside the scope of this thesis, it is instructive to note that cultural differences between NHS and social care organisations (both public organisations) have been much written about (Peck and Dickinson, 2008, Mannion and Davies, 2015). It is given as a reason for difficulties in establishing NHS/public sector partnership working. As discussed in section 2.7, this contrast of values between two public bodies can be

even more pronounced when public and private sector organisations look to establish a partnership.

3.3.2 Public Sector/Voluntary Sector Partnerships

The voluntary and charitable sector was instrumental in developing many of the services that became an accepted part of the UK's welfare state, including education, health care and social services. The underlying variety in the nature of the voluntary sector is illustrated in the mapping undertaken by Kendall and Knapp (1996). They estimate that between 200,000 and 400,000 voluntary organisations are spending around £30 billion, of which 40 per cent arises from government funding, and with almost one million paid employees. The traditional form of relationship between the public/voluntary sector involved the voluntary sector initiating new forms of service that the state may adopt – as it did on creating the NHS - or filling gaps in public provision, sometimes supported in this role by government grants.

However, a more directive collaboration emerged during the 1970s and 1980s. This had two contradictory stimuli. The first was the creation of major public programmes, which, partly because of the target groups they were designed to reach, required the active involvement of the voluntary sector in their delivery. The second factor was the change of role of the state. The search for alternative service providers and value-for-money in public spending resulted in the recasting of the collaborative relationship. General grants that supported an organisation's core costs and service delivery were replaced by more focused contractually based funding for a defined service. More recently, the language of the market has been softened, 'contracts' with voluntary sector bodies are called 'service level agreements, and the form of collaboration is described as 'partnership' rather than 'contracting'. A positive example of this is Diabetes UK, a leading UK charity working with Public Health England to halt the rising number of people diagnosed with Type 2 diabetes. They run joint programmes to educate people about their risk, encouraging early diagnosis and promoting simple lifestyle changes to help prevent or delay its onset.

On 31st January 2019, NHS England published its Universal Personalised Care strategy, following up from the long-term plan, which provides a detailed plan of action to enhance people's choice and control over their health and care. As part of

the strategy, voluntary, community and social enterprise sectors are encouraged to support people to do this. However, as with partnerships with social care, it is not always easy for the voluntary sector to partner with the NHS. On the one hand, the NHS struggles to engage with a highly fragmented market where it's hard to know who can do what best. But, on the other hand, the voluntary and community sector is often excluded from procurement procedures set up for much larger organisations (Khan, 2019).

3.3.3 Public Sector/Private Sector Partnerships

PPPs refer to organisational models that involve public bodies and the private sector working in partnership. It is not a new phenomenon. Boyle (1993) highlights a relationship between the state and business in managing the economy of West Central Scotland from the 1930s. The idea gained traction from the 1960s within the urban renewal experience of the USA. Research by Hodge et al. (2018) suggests that there have been four stages in PPP development since 1992. In the early period (1992-2001), PPP policy and projects mainly occurred in the UK, followed by Australia. Their use was encouraged by government policy and boosted by the Private Finance Initiative (PFI). However, as argued later in the thesis (chapter 3), it is debatable whether this initiative constitutes partnership working. Between 2002-2007, the PPP policy idea took off internationally, particularly to Canada, France and Spain, during economic growth and positive sentiment around the global economy. The Global Financial Crisis saw a period (2008-2012) in which many PPPs floundered, and many more would have gone to the wall without government support. The rationale for using PPPs as a means to bring 'discipline' to the public sector and of private sector efficient risk-taking was forcefully questioned (Roberts, 2011). The most recent period (2013 - 2017) has seen PPP re-adoption in countries that used it before. Still, there has been interest in many other countries, which has led Hodge et al. (2018, p. 1108) to call this the era of globalised PPP policy ideas and language. They state:

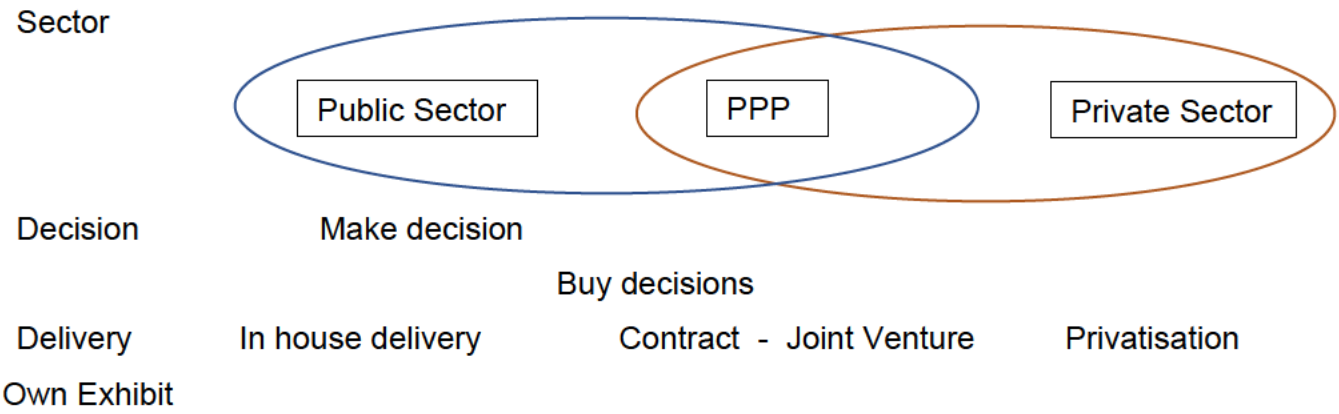
> 'The initial narrow conception of a western project delivery technique has thus evolved into a global PPP policy agenda with a much broader meaning covering everything from economic development and infrastructure governance to multiple project delivery options'.

The historical development of PPPs outlined above is of interest. It shows that this type of partnership is still very relevant to conducting business and recent research indicates that they can be successful. For example, in a report on the effectiveness of NHS partnership working, Miller and Millar (2017, p. 28) comment:

> 'Partnering can be successful between NHS and private organisations and bring helpful diversity of resources, skills and networks.

PPPs arise from the make or buy decisions that governments face. Governments can choose to realise societal goals directly, through public employees and collectively controlled facilities called the make decision, or indirectly utilising business organisations called the buy decision (Osborne and Gaebler, 1992, Williamson, 1996). The researchers interpretation of the spectrum of PPP choice is depicted in figure 2

FIGURE 2: CLASSIFICATION OF PPPS



Own Exhibit

Combining the multiple strands of PPP theory outlined above, the definition of PPP developed by Van Ham and Koppenjan (2001, p.598) is a useful framing for the core of the thesis as it includes both structure and agency aspects:

> 'Cooperation of some sort of durability between public and private actors in which they jointly develop products and services and share risks, costs, and resources which are connected with those products.

Skelcher (2005) suggest that four important questions need addressing by public managers before they decide to engage in a PPP. First, does the rhetoric of common interest between the parties exclude significant differences of value and motivation? For the public sector, relational contracting benefits from identifying a preferred

partner with whom to work towards societal goals over the long term. This contrasts with the position for the private sector, where entering a partnership is an effective business strategy that is based on an assessment of market conditions and driven by considerations of competitive advantage (Faulkner and De Rond, 2000). Second, there is the issue of trust. The notion of trust is integral to the value set of the public sector and is reinforced through institutional arrangements. The same cannot be assumed of the private sector. From a business context, the building of trust is a process that leads to the cementing of a deal. It is not an intrinsic value. The third question concerns the extent to which public organisations can engage in PPPs. They are sometimes challenging to resource, and when central funding is reduced or removed, the danger is that the public interest is side-lined. The fourth and final question is how do PPPs interact with democratic institutions and processes? Creating PPPs with the NHS is a highly political venture. The political climate has had some seismic shifts over the past thirty years, which have had an enormous impact on the ability and desire of public organisations to enter into partnerships. These were extensively discussed in the previous chapter.

Although providing an overall description of PPP for this dissertation, the analysis above shows that there are numerous public and private organisations in some sort of relationship described as PPPs by governments, academics and practitioners because the concept of partnership is so disputed. Having already decided to exclude PFI contracts between public and private companies from this thesis because they are market-based rather than partnership-based relationships, it is important to put additional limitations around what can be termed a PPP in the context of the thesis. A way of doing this is to compare the level at which each partnership is working, moving from a purely contractual arrangement to a strategic partnership. The private sector organisation's involvement in the partnership can then be depicted as a spectrum using these levels.

3.4. PPP Spectrum

Taking the suggestion of researchers such as Briggs (2010), Dhillon (2013), PPPs are conceptualised as a spectrum from weak to strong forms of partnership. Figure 3 shows this in diagrammatic form.

FIGURE 3: PPP SPECTRUM

Own Exhibit

3.4.1 Short-Term Partnering Contract

Short term partnering contract or contracting-out involves separating the purchaser of service from the provider. Another description for this type of contract is principal-agent. The public authority (the principal) specifies the service to be delivered, including any necessary service standards, policy obligations, and legal requirements to be met. The contractor (the agent) agrees to provide these in return for a fee. Contracting-out is the predictable outcome of a competitive tendering or market-testing process. The public provider is deemed not to offer the best solution or has constrained capacity. But this simple relationship contains complexity. Problems arise because there are strong incentives for the contractor to minimise costs and maximise revenue in a competitive market. For example, the principal will require regular monitoring information on performance and make payments on this basis. However, the agent is better able than the principal to know the reality of performance against specification, leading to the problem of information asymmetry. The ability of an agent to control (fully or partially) the quality, quantity and timeliness of the data provided to the principal is a powerful resource in the relationship. This imbalance of power is exasperated because contracting out is typically based on

relatively short-term contracts. The traditional view is that this type of contract operates in name only when called a partnership. However, a more nuanced view is that because the public authority has selected a partner to assist them in the service provision, they can become more collaborative and less adversarial even in relatively short contracts. This is why on the spectrum, this type of contract can move from no partnership to a weak form of partnership

3.4.2 Longer Term Partnering Contract

No specific time scale is made clear in the literature about when a short-term contract moves to a long-term contract. Still, a helpful way of viewing the difference is provided by Klijn and Teisman (2000, p. 85), who express it as the difference between contracting-out and partnership:

> ‘Contracting-out is characterised by a principal-agent relationship in which the public actor defines the problem and provides the specification of the solution…On the other hand, a partnership is based on joint decision making and production to achieve effectiveness for both parties. Therefore, relational transparency, or in other words trust, is crucial’.

The notion has informed the longer-term collaboration of relational contract theory, which predicts that behaviour rather than rules shape contractual relations (Macneil, 1983). Those advocating relational contracting argue that trust and mutuality will replace the suspicion and divergence of interests in traditional short-term contracting. Partners are in the relationship for the long term, thus requiring a more open and transparent engagement.

3.4.3 Franchising

Franchising involves government awarding a licence to a business to deliver a public service in which the provider’s income is in the form of user fees. Franchising has a particular benefit in the case of a monopoly public-interest service whose revenue is sourced from user charges or taxation and where the government does not want to develop and/or operate the service directly itself. This is because the monopoly features of the service make privatisation problematic or undesirable (e.g., selling an NHS hospital to the private sector). Franchising provides a means of transferring operational responsibility to the business sector, with the government taking on the role of an arm's length public interest regulator.

3.4.4 Joint Ventures

Joint ventures occur where two or more parties wish to engage in a collaborative project in a way that retains their independence (Schaeffer and Loveridge, 2002). The joint venture may be managed through a partnership agreement or a separate corporate entity – a special purpose vehicle (SPV). This is a strong form of partnership as it enables joint working, a pooling of assets, and the pursuit of complementary objectives (DCLG, 2006).

3.4.5 Strategic Partnering

Strategic Partnering was a new form of longer-term public/private relationships created in the early 2000s and was developed to focus on a complex package of relationships between a public organisation and a company or consortium. Throughout the decade, the political and managerial climate encouraged this type of partnering. Byatt (2001) argued for the development of a more sophisticated and strategic approach to the procurement of goods and services by local authorities and a greater willingness on the part of a business to understand and invest in the development of local government services. Field and Peck (2004) suggest that a strategic partnership will involve both parties in the strategic planning process and share the joint working risks.

3.5 Conclusion

This chapter has highlighted the many contested views amongst academics of the partnership concept. It analysed the reasons why organisations and managers are motivated to try and partner. Dickinson and Glasby (2010) note that this desire to partner is often hope over experience as there is a distinct lack of evidence for successful partnerships. Once organisations agree to partner, then governance arrangements become key to how they operate in practice. It looked in detail at the many ways that partnerships can be controlled. The decision to use a particular type of governance arrangement is influenced by the type of organisations looking to work together, the perceived complexity of the partnership, or the stage of the partnership lifecycle. The chapter then considered the three distinct forms of partnership that occur when involving the public sector. The literature is abundant when looking at either public/public and public/voluntary sector partnership working but as these types of partnerships are not the primary focus of the thesis, only a summary is

provided. The research on PPPs is much scarcer, making it more difficult to apply, but it also provides scope for the thesis to add to the PPP research literature. Vaillancourt Rosenau (2000) suggests that partnerships between public and private organisations give rise to a series of additional ideological and managerial choices. These concern the relationship between private companies and the state, the extent to which businesses should substitute for the government, and the cost and benefits of different public and private solutions. The amount of strategic involvement in the partnership by the private sector organisation is depicted as a spectrum. The focus in the literature on structure and organisational aspects of partnerships discussed in this chapter at the expense of neglecting the importance of individual actors started to come in for criticism (Klijn and Teisman, 2003). These individuals are the subject of the next chapter.

CHAPTER 4 – BOUNDARIES, BOUNDARY LEADERSHIP AND BOUNDARY SPANNERS

Recognising that the answer to creating effective partnerships might not reside solely at the organisational level, academics working across different sectors highlighted that the collaboration literature needed to focus more on the roles played by individual actors. Referring to private alliances, Hutt et al. (2000, p. 51) et al comment that: 'Surprisingly, human or people factors appear to have remained unconsidered or, at worst, dismissed, in the alliance research tradition'. Concerning the public sector Williams (2002, p. 106) states: 'the fixation at the inter-organisational domain level understates and neglects the pivotal contribution of individual actors in the collaboration process. In reference to public-private partnerships, Noble and Jones (2006, p.891) argue that: ‘the PPP literature is dominated by institutional and organisational level discourses to the detriment of analyses of the dynamic role of individual actors in the management of this form of inter-organisational relationship’.

The solution offered by Williams (2002) and picked up by other scholars (Marchington et al., 2005, Noble and Jones, 2006, Lindsay and Dutton, 2012, Durose et al., 2013) was to suggest that agency (in the form of individual actors) who lead and manage the partnership are an important way in which different partners can be brought together and manage the complexity of partnership working. This thesis proposes that a way of understanding the roles and responsibilities of these actors is to think of them having to bridge somehow the boundaries of the organisations making up the partnership. In other words, the challenge can be thought of as boundary management (Malone and Crowston, 1994, Gittell, 2001). Section 4.1 reviews the theory around boundaries and boundary work which leads into section 4.2 that looks at the role of boundary leadership within a PPP. Having concluded that it is vital to manage across the organisational boundaries within a PPP, section 4.3 looks in detail at the roles and skills required for boundary spanners to be successful.

4.1 Boundaries, Boundary Objects and Boundary Work

There are several ways in which scholars have approached defining boundaries. Focusing on the micro level, one of the most cited definitions is by Aldrich and

Herker (1977) who talk about boundaries demarcating between members and non-members. The theme is picked up by Gieryn (1999) who suggests that boundaries separate actors into insiders and outsiders and Barth (1969, p. 15) described boundaries as something that 'defines the group, not the cultural stuff that it encloses'. Another focus is on the way boundaries are formed and then modified over time due to ‘subtle and complex products of action’ (White, 1992, p. 127) which may lead to actors being excluded from decisions and interactions (Long Lingo and O'Mahony, 2010). Boundaries have also been differentiated by their properties. For instance, Hernes (2004) suggests that they can be mental, social or physical and Lamont and Molnar (2002) highlight their ability to be social or symbolic.

However, the focus of this thesis is on organisational boundaries which means that mainstream organisational theory provides the most relevant literature. Santos and Eisenhardt (2005, p. 491) define the organisation boundary as the ‘demarcation between the organisation and its environment’ and in a similar vein Pfeffer and Salancik (2003, p. 113) suggest boundaries are where ‘the organisation ends and the environment begins’. The idea of the organisation/environment split has been developed by open system theorists who use the imagery of the boundary as permeable but still acting as a barrier (March and Simon, 1958, Perrow, 1986). As stated in chapter 1, the concept of boundary is interpreted as demarcating an organisation from its environment and the boundary wall framework develops this interpretation and with it the idea that it is possible for ‘boundary spanners’ to move in and out and across organisational boundaries.

Like Leonard (1995), this researcher believes that working across boundaries is crucial for competitive advantage and is also an immense management challenge. Meier (2015) points out that the detached nature of research between the study of boundaries and its practice makes it problematic. One way of dealing with this difficulty is to look at how the boundary literature has explored and developed the concept of boundaries and boundary work in several different industries and settings (Lamont and Molnar, 2002, Perrone et al., 2003, Hernes, 2004, Carlile, 2004, Rao et al., 2005, Mizrachi and Shuval, 2005, Kellogg et al., 2006, Kreiner et al., 2009, Helfen, 2015, Stjerne and Svejenova, 2016, Radoynovska, 2018, Comeau-Vallée and Langley, 2020). Hernes (2004) suggests framing boundaries by having three potential dimensions: physical, social and mental. Physical boundaries can be actual

partitions within the workplace but can also include regulations and rules. Social boundaries focus on the people within an organisation and are reflected in how they bond together (or not). This bonding will generally be reflected in things like loyalty, group identity and trust. Mental boundaries refer to beliefs that allow people to feel part of or excluded from a group. For instance, Weick (1995, p. 176) suggests boundaries within which ‘explanations hold and outside of which they do not hold’. Pouthier (2017) suggests gossip and moaning about the organisations making up the partnership is an alternative way of crossing mental boundaries.

For an alternative view on framing boundaries and boundary work, the work of Carlile (2004) is helpful. He summarises boundary research into three different strands of literature that investigates the movement of knowledge. The first emphasises information gathering and dissemination that sees knowledge as a thing to collate and retrieve; the second is an interpretive approach that emphasises finding ordinary meaning between actors when sharing knowledge, and the third is a political approach that recognises the different interests between actors can impede knowledge sharing at the boundary. The thesis will explore each framing in turn.

4.1.1 Information Gathering Boundary – Transferring Knowledge

It was not until the 1960s that researchers broadened their scope to write about what was external to the organisation. Most early organisational theory was focused on the internal workings of organisations. Taylor (1911) and other advocates of Scientific Management (the first systematic theory of organisations) formulated their principles of efficiency by studying and altering specific work practices in factories and offices. The Hawthorne studies (Roethlisberger and Dickson, 1939), which began as an experiment in environmental design, provided detailed observational data on work practices and which an entire generation of theorists anchored their theoretical claims (Argyris, 1956, Homans, 1950, Likert, 1961). During the 1960s and 1970s, however, organisation theory gradually moved from focusing on the internal dynamics of organisations to looking externally. The shift was associated with several trends in the discipline's development, including a focus on *systems theory*. Thompson (1962), a strong advocate of open systems theory, conceived the name 'boundary panning for the process of managing the interface between organisations and their environment. Thompson (1962, p. 309) states:

> ‘Complex purposive organisations receive inputs from, and discharge outputs to, environments, and virtually all such organisations develop specialised roles for these purposes. Output roles, designed to arrange for distribution of the organisation's ultimate product, service, or impact to other agents of the society thus are *boundary panning* roles linking organisation and environment through interaction between member and non-member’.

Thompson conceptualised boundary spanning as collecting information about the external environment and transmitting it to organisational decision-makers to make appropriate decisions relevant to environmental conditions.

Taking their cue from Thompson, some of the earliest organisational research on boundaries started by acknowledging and trying to explain why organisations need to manage their boundaries with other organisations in their environment and attempted a theoretical identification of boundary activities. Katz and Kahn (1966) saw three boundary panning roles. The first role was procuring resources and disposing of outputs. The second role was relating the organisation to its larger community or social system. The third role was to ensure the organisation adapted to the future by gathering information about trends. In a similar generalist view, Leifer and Delbecq (1978) saw the function of boundaries as protecting the organisation from environmental stress and acting as regulators of information and material flow between the organisation and its environment. Aldrich and Herker (1977) proposed two primary classes of boundary management, namely information processing and external representation.

Some researchers writing about boundary activities at this time were influenced by the theory of role dynamics proposed by Kahn et al. (1964). They postulated that stress in employees was caused by conflicting, incompatible, or vague expectations. Several scholars (Adams, 1976, Sell et al., 1981) associated this role conflict or ambiguity directly with the boundary role. However, the emphasis on the dissonance for boundary individuals appears to wane from the late 1970s onwards as other research showed contrary findings. For instance, Keller and Holland (1975) found boundary roles to be advantageous for their incumbents. Employees in these roles had more accurate perceptions of their organisation's goals and purpose (hence less

role ambiguity) and more high profile contact with top management (resulting in higher job satisfaction).

Also influential on how and why organisations need to look beyond their boundary is the work of Child writing about strategic choice (Child, 1972, 1997). He emphasises that partnerships need to consider human agency and the subjective nature of choice to counteract the pervasive influence of environmental factors. This tapped into the growing interest around social network properties of organisations and their contexts (Nohria and Eccles, 1992). Concerning boundaries, Child (1997, p. 58) makes the important point that researchers should pay attention to the way actors within partnerships seek to realise their goals through 'the relationships that extend across an organisation's boundaries'. This emphasis on processing knowledge at the boundary rather than just collecting and disseminating it leads to the second strand of literature highlighting the idea that boundary work is used to translate knowledge between boundaries.

4.1.2 Interpretive Boundary – Translating Knowledge

A lot of the emphasis in the literature about boundary properties is that of demarcating individuals or groups from each other, leading to a discontinuity in or exclusion from decision making and interactions (Long Lingo and O'Mahony, 2010, Akkerman and Bakker, 2011). These theories point out the problems that this type of boundary can cause and how it must be recognised and overcome. In her seminal paper on collaborative advantage, Kanter (1994) talks about the most productive partnerships achieving five levels of integration, one of which she calls *Interpersonal integration.* She suggests that as a partnership matures beyond the early days, the network of interpersonal ties between members of the separate organisations must grow in extent and density. Kanter (1994, p. 106) quotes one manager as saying:

> 'If you don't establish good rapport with your counterparts, you haven't got a prayer of making it work. Formal structures of decision making don't do anything for you unless you've got the relationship to start with'.

Theories on boundary spanning were developed where individuals, often in specific boundary panning roles as will be highlighted in section 4.2, work to link and broker knowledge between different social entities (Long et al., 2013). These individuals must overcome the situated and interpretive challenges of translating this knowledge

across boundaries (Nonaka and Takeuchi, 1995, Spender, 1996). The term boundary object stems from research by Star and Griesemer (1989). They wrote about how scientists at the Museum of Zoology used boundary objects to help develop common meanings to address interpretive differences. More recently, Sullivan and Williams (2012) talk about boundary object theory being a particular way of defining and discussing objects that derive from the need to understand the role and function of objects where multiple stakeholders with numerous interests need to be able to collaborate. Sullivan et al. (2013) believe that focusing on 'objects' can generate new insights into collaboration that improve our understanding. Crosby and Bryson (2010, p. 205) comment:

> ‘Boundary objects and their development help participants make sense of their world, what they may want to do with it, and why, and, in doing so, they...help connect people, ideas and other actors into a way forward’.

This process of boundary framing (Benford and Snow, 2000) or making sense (Weick, 1995) of their surroundings for others in the partnership is crucial as it points to a vital role that boundary spanners need to fulfil (section 4.2.2) and one that this thesis looks to investigate.

4.1.3 Political Boundary – Transforming Knowledge

The sociological literature has comprehensively documented the development and maintenance of the system of professions. Abbott (1988) influential research shifted the analytical focus from external organisational boundaries to internal professional/disciplinary boundaries. Gieryn (1983) described how professional people continuously draw and redraw boundaries as 'boundary work'. Just as there are many shades of boundary, there are diverse types of boundary work. Gieryn (1999) noted protection of autonomy, expansion and expulsion among scientists as three different types of boundary work. These internal boundaries, and in particular the way healthcare professionals create, maintain and defend them, has attracted much attention from researchers (Fournier, 2002, Sanders and Harrison, 2008, Martin et al., 2009, Powell and Davies, 2012, Chreim et al., 2013, Bucher et al., 2016). For instance, Martin et al. (2009, p. 1191) discuss how the boundary between two different sets of medics was 'opened, negotiated and reclosed'. This research focus on professional boundaries is fascinating and relevant when looking at

knowledge transfer across internal boundaries. However, this thesis investigates how knowledge is moved across organisational boundaries. Healthcare research shows that organisational boundaries have an impact different from internal boundaries (Pugh et al., 2003, Senior et al., 2003, Glickman et al., 2007). Therefore, the internal or political boundary has been excluded from further consideration in this thesis.

4.2. Boundary Leadership

This thesis uses the term boundary leadership to characterise the role of leaders within a partnership setting. Reviewing the research that has been written about partnership leadership, much of the early literature takes single organisation leadership theory and extrapolates it to encompass multiple organisations (Bass and Stogdill, 1990). However, the extent to which approaches relevant to a single organisation can be adapted into a partnership context is unclear. Pettigrew (2003) suggests that partnership leadership should be reappraised compared to single organisations working in partnership is of an order more complex. Agreeing with this recommendation, two strands of literature seem to be most relevant, along with looking at new emerging trends. The first strand interrogates the structural factors in determining the space and scope for leadership, including the type of work the partnership is undertaking, the characteristics of fellow managers, and the external environment (this is often summarised as the situational approach). The second strand emphasises the importance of leadership traits and styles for successful partnership leadership (agent-orientated approach).

4.2.1 Situational Leadership

Situational leadership suggests that leadership styles have to be adopted to respond to the demands of a given situation. Dickinson and Carey (2016, p. 26) state that this way of thinking established a crucial relationship between context and leadership that has become increasingly influential and' shapes many leadership development programmes delivered today'. Academics have linked problem type (Grint, 2005) with leadership focus, arguing that collaborative settings are populated by ‘wicked issues’ which demand partnership leadership based on four principles: inspiring commitment and action; leading as a peer problem solver; building broad-based involvement; and sustaining hope and participation.

Vangen and Huxham (2003) extend the skill requirements of partnership leaders by suggesting they need to be adept at both facilitation and 'thuggery' and at managing the interaction between them. They see the thuggery or, as Dickinson and Carey (2016) suggest, the 'manipulative' part of the job influences the purpose and direction of the partnership. They suggest both aspects are needed to generate collaborative advantage.

Bryson and Crosby (1992) proposed the idea of leadership needing to be split in an inter-organisational public sector context. They suggested that leadership may be expressed through the processes operating within partnerships. Feyerherm (1994, p. 268) found that in her research:

> 'Leadership as a property centered in one person may be an obsolete way of viewing leadership. Leadership functions and behaviors were widely shared among many of the members of these two groups'.

Armistead et al. (2007) comment that this perspective means that leadership can take on an impersonal nature, built into systems for inspiring and nurturing a partnership. However, they believe it would be ridiculous to suggest that processes alone detail the extra dimensions of leadership needed for a successful collaboration.

4.2.2 Agent-Orientated Leadership

Sullivan et al. (2011) promote the idea that influential contributors to agent-orientated leadership discussed new leadership traits and styles appropriate for 'collaborative leadership'. The identification of 'charismatic' (Bryman, 1992), 'transformational' (Peters et al., 1982) and 'visionary' (Bass, 1990) prescriptions for leadership was necessary as they suggested a view of leaders as managers of meaning, articulating the potential possibilities of the partnership through visions, missions and core values. The research by Feyerherm (1994) also emphasised the importance of leaders as managers of meaning and understanding how others may view the world. Slater (2005, p. 331) drew attention to the need for leaders who:

> '…wish to work in collaborative ways involves recognising, understanding, and managing the emotional aspects of the collaborative process'.

Bardach (1998) identified two contrasting styles – facilitative and advocacy. A facilitative style is inclusive, consensual and diplomatic and brings together actors in an open process. In contrast, an advocacy style might be more appropriate where reaching an agreement is unrealistic and the leader is prepared to ignore specific interests in pursuit of a particular goal or outcome. Fullan (2001) identifies five agent-centric components of effective leadership: moral purpose, understanding the change process, relationship building, knowledge creation and sharing and coherence making. This links to Luke (1998) focus on 'catalytic leadership' tasks and the ability to undertake them, including an ability to think outside the box; excellent interpersonal skills; the need for a character which is passionate about achieving results; an ability to relate; complete personal integrity and strong ethical conduct. Finally, the research by Kanter (1997) on 'cosmopolitan leaders' emphasised the need for high intelligence and mental toughness in collaborative settings.

4.2.3 New Trends in Partnership Leadership

Other fields of study perhaps not previously associated with leadership studies are being examined to increase the understanding of leadership. For example, complexity theory has also been applied to the idea of leadership. Klijn (2008) suggests three important management concepts can be found in complexity theory. The first is that the complexity and the multiple properties of complex systems will make these systems *unmanageable*. Flood (1999) calls this ‘managing within the unmanageable’. The argument is that since partnerships form a complex system, adjusting to changes in the way they develop is often a wiser strategy than trying to alter their direction through managing them. In this situation, a leader adapts to developments rather than trying to direct them. As Flood (1999, p. 256) states, leadership becomes much easier if there is:

> '…a humble awakening to the realisation that we don't really know very much about anything and actually never will'.

The second contribution to the theory of leadership from complexity theory points to *intelligent interventions*. If complex systems are unpredictable, then precise knowledge about each specific situation is necessary. Therefore, interventions should be explicitly aimed at a system's characteristics and establish specific interactions between actors that realise outcomes that achieve the desired direction.

Here, just as in the governance perspective, a leader is part of the complex system he is managing and interacts with the separate actors to influence interaction patterns and outcomes. This view chimes with the literature on network management (Kickert et al., 1997). A leader has a facilitating role in connecting relevant people to achieve the ongoing aims of a partnership.

The third inspiration from complexity theory is the view of a leader as *riding the fitness landscape*. For example, suppose the events in a partnership are seen as a range of mutual influencing interactions, where choices and events shape new situations and actors' positions (the fitness landscape). In that case, the leader's task is to be aware of the opportunities in that landscape, as well as the positions of the actors to fit the landscape. This perspective is similar to the previous one. Still, the leader has the added responsibility of profoundly understanding the landscape and how actors should fit together to bring about the smooth running of the partnership.

There is also a range of theories that can broadly be described as theorising *distributed leadership.* Distributed leadership can be characterised as situations in which practitioners collaborate at different levels to create a sense of shared direction and purpose. In this organisation type, the idea of leadership as a characteristic of individuals becomes redundant, and the difference between leaders and followers becomes indistinct to the point of worthlessness (Spillane, 2004). This view is attractive in partnerships, highlighting leadership as a collective task (Drath, 2003).

This section has reviewed the leadership literature as it pertains to the complex world of inter-organisational partnerships. It has highlighted how different leading in a partnership is compared to leading in a single organisation. Particular strands of literature stood out as most relevant and were explored: situational leadership, agent-orientated leadership, and the new trends in leadership literature were briefly interrogated. What helped pinpoint more relevant literature was to think about how to manage the many complex interactions between the PPP organisations. To improve the effectiveness of these interactions, a focus is needed on individuals working across these organisational boundaries. The individuals tasked with this role are often referred to as 'boundary spanners' (Friend et al., 1974, Leifer and Delbecq, 1978, Steadman, 1992, Williams, 2002). To understand boundary spanners further,

the following section interrogates the research through the two lenses of IOR literature and public collaboration literature.

4.3 Boundary Spanners

McCray and Ward (2003, p. 362) suggest partnership working is often 'the action of a few individuals with vision that have created change in service delivery in relation to people's lives and opportunities. In other words, certain managers are viewed as essential in making a partnership work. The literature has thrown up numerous definitions of the boundary spanner role; some of the most common are outlined in Table 9 below.

TABLE 9: CHANGING DEFINITIONS OF THE 'BOUNDARY SPANNER'

Author	Name	Definition
Adams (1976)	Boundary Role Persons (BRPs)	A BRP is an individual who is responsible for contacting people outside his or her own group
Friend et al. (1974)	Reticulist	Requiring excellent Interpersonal skills, and cultivating relationships
Leifer and Delbecq (1978)	Linking pin	Joining two organisations together
Challis et al. (1988)	Entrepreneur	Creative, 'outside the box thinker and rule breaker
Trevillion (1992)	Cultural broker	Ability to empathise with the other organisations in the partnership
Steadman (1992)	Boundary Spanner	A position that links two or more systems whose goals and expectations are at least partially conflicting
Williams (2002)	Boundary Spanner	Set of individuals who have a dedicated job role or responsibility to work in a multi-agency and multi-sectorial environment

Own Exhibit

As one can see from the definitions, academics have given attention to a range of variables, including organisational structure, roles, networks, communication, teamwork, and decision making. Against this backdrop, it is necessary to look at strands of literature that have the most relevance to the topic. Two lenses are used

to frame existing research. First, attention has been paid to looking at how boundary spanners have been discussed in inter-organisational and public collaboration literature. The reason for including the first literature strand is self-evident (Cropper, 2008). Second, research on the management of PPPs is treated predominantly in the public collaboration literature (Joyner, 2007). Both kinds of literature have seen a significant increase in scholarly activity over the past twenty years, offering exciting insights.

4.3.1 Situating Boundary Spanners in the Inter-Organisational Literature

The general inter-organisational literature is vast, and for most researchers, until quite recently, there has been little or no mention of boundary spanners. They assumed that the formal contracts between organisations could specify and determine relations well enough to mean that there was no need to consider the role played by individual actors acting across organisational boundaries. Even studies that do explicitly deal with the work of boundary spanners, e.g. Ring and Van de Ven (1994, p. 98), refer to it as `backstage interpersonal dynamics' in other words, it does not count as a typical activity.

However, with the increasing interest from academia and politicians in the concept of partnership working, the IOR literature devoted to reviewing agency factors has expanded rapidly. Therefore, to bring structure and clarity to this section, it is assumed that boundary spanners are part of the formal management of the partnership. This means only a subset of theories that underpin the IOR management literature need to be considered. These include psychology, sociology, economics and political science. In these studies, a wide range of management issues has been considered. These include managing relationships, managing alliance portfolios, the development of influence and management styles. However, the vast majority of this research focuses on the general workings of partnership rather than the specific job of working across the organisational boundaries and therefore offer little or no insights into the role of the boundary spanner.

Researchers who focus on the management of the partnership itself often conceptualise their recommendations in terms of strategies or tasks that will 'foster collaboration' (Gricar and Brown, 1981, p. 403). A related body of literature is concerned with network management, as the partnership has often been equated

with the network form, focusing on horizontal relationships. Because of the complex nature of PPPs, researchers have suggested partnership managers (boundary spanners) need to adopt network management activities and strategies to achieve good outcomes (McGuire and Agranoff, 2011). Research shows that two types of network management strategies seem to have the most impact: exploring and connecting (Klijn et al., 2010). Exploring strategies aims to create and look at new solutions, collect partnership information, and resolve conflicting points of view. Connecting strategies aim to bring actors together, activate resources, and deal with conflicts (Warsen et al., 2018).

Kickert et al. (1997) slightly different perspective pose a network is a looser set of relationships than other IORs such as partnerships or strategic alliances. The task is to promote the mutual adjustment to each other of actors within a framework of inter-organisational relationships. They suggest three elements: intervention in an existing pattern of relations, consensus building, and problem-solving, and offer several strategies for achieving these. As with alliance management, there are many examples where collaboration and network management has been expansively elaborated (Gray, 1989, Koppenjan and Klijn, 2004).

4.3.2 Situating Boundary Spanners in the Public Collaboration Literature

When analysing the literature on public collaboration and the involvement of boundary spanners in how each partnership operates, contributions have come from a large number of disciplinary perspectives. Huxham and Vangen (2004) suggest sociology, business policy, economics, economic geography, public policy, politics and management. Surprisingly though, only a minimal amount of this research explicitly addresses the actual process of partnering. However, two interdisciplinary approaches in the literature seem relevant, and they are outlined below.

4.3.2.1 Roles and Competencies of the Boundary Spanner

In their study of managing partnerships in the NHS, Ferlie and Pettigrew (1996) found that managers responding to their questionnaire suggested that 'trust', 'reciprocity', 'understanding' and 'credibility' were all critical skills needed to be successful. Williams (2002), focusing mainly on individual boundary spanners, defines competencies as the combination of particular skills, abilities, experience, and personal characteristics. He argues that effective boundary spanners

demonstrate competencies for building sustainable relationships, managing through influence and negotiation, managing complexity and interdependencies, and managing roles, accountabilities, and motivation. Expressed at this level, the competencies approach still focuses principally on tasks that have to be carried out. Only when the tasks are examined at a more detailed level, do individual capabilities that contribute to these enactments become evident. Feyerherm (1994) arrives more directly at behaviours in a longitudinal study of people identified as influential collaborative leaders. Her list of fourteen items includes, among others: reasoning, bridging, using humour, and providing examples and analogies. Several key features emerge from this list of behaviours.

It is recognised that the work of boundary spanners is complex and potentially contradictory because they operate at the edge of organisations, often trying to persuade other people over whom they have no absolute authority. On the one hand, this means that they need to be continually aware of their own organisation's needs, move between reliance on strict contractual requirements, and an eagerness to take advantage of deals that are likely to benefit their organisation. On the other hand, they must empathise with the needs and priorities of those working for collaborating organisations and appreciate the effect their actions may have on longer-term and broader inter-organisational relations. As Marchington et al. (2005) highlight, issues of trust, risk, and power are intertwined in all of these considerations. In his further work on boundary spanners, Williams (2012) presents 'types' of boundary spanners, with each playing different roles and demonstrating a range of competencies to enable them to discharge their roles to best effect. The thesis will discuss each aspect in turn.

The first role, *reticulist*, focuses on understanding and managing internal and external relationships with the organisation. Webb (1991, p. 231) defines them as ‘individuals who are especially sensitive to and skilled in bridging interests, professions and organisations’. Ebers (1997) refers to reticulists as 'informational intermediaries' who act as lynchpins to bridge the gap in asymmetrical information flows, help establish a standard set of goals and improve coordination. Wilson and Charlton (1997, p. 51) guide to effective partnerships suggest that reticulists need to be comfortable working within informal decision structures, and the 'skill is to use informal networks, links and alliances to build positive relations between all the

different parties'. This in turn requires good communication and negotiation skills (Williams, 2012). Aldrich and Herker (1977) suggest that a crucial role of the Reticulist is to filter and transmit information to and from an organisation's environment.

The second role suggested by Williams (2002) is that of *interpreter/communicator*. Partnership environments invariably bring together a diverse range of stakeholders from different backgrounds, professions, cultures and organisations, who view the world differently, embrace other professional practices and ways of working, and are stimulated to work cooperatively through different motivations (Williams, 2011). The metaphor of a ’cultural broker’ Trevillion (1992) emphasises the importance of boundary spanners to understand and respect other peoples' values and opinions. Being a good listener and using diplomacy and negotiation ensures that people can work together harmoniously. Rieple et al. (2002) see the value of boundary spanners in understanding the cultural and linguistic norms of various partners and being able to translate this into practical action by bypassing organisational roadblocks. This role can also help overcome the almost universal frustration felt about infrequent attendance by managers involved in the partnership by building and using personal relationships in the decision making processes. Trust is widely recognised as being fundamental. Lane and Bachmann (1998, p. 03) offer a list of common elements in conceptualisations of trust, including:

- ‘An assumption of a degree of interdependence between the trustor and trustee
- Trust provides a way of coping with risk or uncertainty in an exchange relationship
- Trust is a belief or expectation that the vulnerability resulting from acceptance of risk will not be taken advantage of by the other party in the relationship’

This third element is often translated into trust built by boundary spanners who interact and deliver on their commitments over time. However, on the other side of the coin, the fragility of some trust-based relationships can be seen by the downward spiral of distrust, often caused by events outside the control of the boundary spanner, resulting in dysfunctional working relationships.

The third role suggested is that of *coordinator*. Boundary spanners are often called on to support and facilitate the multi-faceted and complicated decision-making processes that accompany partnership working - the informal meetings and conversations, the negotiations and the investment in social capital that underpins the formal machinery of partnership (Williams, 2012). One of the advantages of this role is that being at the centre of the information highway can be potentially very powerful.

The fourth role, *entrepreneur*, sees the boundary spanner focusing on developing new solutions to complex problems or, as Williams (2011) puts it, 'making things happen'. It requires risk-taking, imagination and opportunism – characteristics that have often been frowned upon in the public sector because of bureaucratic modes of organising. The boundary spanner as an entrepreneur needs to be proactive to initiate and broker solutions between the partners. The profile of the effective entrepreneur suggests that they must be creative, socially perceptive, able to mix in a variety of social and political settings, argue persuasively, be strategic team builders, and lead by example (Mintrom, 2000).

It is clear from the above that each role identified by Williams (2012) places considerable pressure on the abilities of boundary spanners. These are not easy jobs as they aim to persuade people to carry out requests that they may not be inclined to follow without the hierarchical power to insist. This puts a significant onus on the competencies or personal attributes that boundary spanners bring to the job. They may be skills (technical and interpersonal), knowledge of particular areas of expertise or accumulated knowledge from carrying out the role for some time. In addition, although not competencies, the personality and work history of the Boundary Spanner are also likely to influence how the roles are performed. Williams (2011, p. 27) suggests that boundary spanners change the way they act depending on what they are faced with:

> 'The individual elements of the boundary spanners' role are deployed in different permutations depending upon the nature of the challenges faced and the tasks involved'.

In Table 10 below, the various skills associated with the roles are presented. This will be very useful later in this dissertation as it will help define the changing roles each boundary spanner plays in my case studies.

TABLE 10: BOUNDARY SPANNING ROLES AND ASSOCIATED SKILLS

Competences	Relevant roles	Skill characteristics
Interpersonal skills	• Reticulist • Interpreter and communicator • Coordinator	• Developing and maintaining relationships and network links • Developing trust • Communicating effectively • Listening and empathy • Negotiation, consensus building and conflict resolution
Cognitive skills	• Reticulist • Interpreter and Communicator	• The ability to understand complexities and linkages between interests, professions, organisations and other factors • Has an appreciation of, and values, different cultures, motivations, perspectives and practices across a range of professions
Managerial skills	• Reticulist • Interpreter and Communicator • Coordinator	• The ability to operate within networks and work with individuals with different and sometimes changing interests • Coordination and planning skills
Political skills	• Reticulist	• The ability to manage relationships between different sources of power using diplomacy and influencing behaviours • The ability to broker solutions through creating and assembling resources owned by others, which require them to influence, motivate and negotiate with others
Entrepreneurial skills	• Entrepreneur	• The ability to develop new solutions to complex problems • Creativity and innovativeness • The ability to capitalise on opportunities • The ability to manage risk • The ability to broker deals between parties with different interests

Adapted from Buick et al. (2019), Williams (2013)

It is suggested that these attributes, skills and competencies are in addition to those required in standard organisational settings. However, at least some of them will be useful in whatever stage they are applied. A further interesting debate occurs in the collaborative leadership literature around the personal characteristics required of leaders and whether they are born or developed. This debate extends to boundary spanners typically viewed as outgoing, cheerful and extrovert, honest, respectful, highly moral, hardworking and persistent (Dickinson and Carey, 2016). Table 11 sets out some of the personal characteristics desirable in boundary spanners, drawing on work by Williams (2005).

TABLE 11: DESIRABLE PERSONAL CHARACTERISTICS OF BOUNDARY SPANNERS

Personal attributes	Description
Respect for others and their views	Appreciating, comprehending and accommodating diversity and differences in people's perspectives and opinions. The keyword here is respect, which does not mean agreement but valuing other people's right to their own views. It is also considered necessary also to look for opportunities to demonstrate this respectfulness and to be tolerant of others' positions on various matters. Innate curiosity about the bigger picture is thought to be an invaluable personal attribute
Honest, straight and trustworthy	Evidenced by being open in dealings with people, not being underhand or devious, or going behind their back
Approachable	This is about people who are accessible and not 'standoffish'; sometimes amusing, talkative and interesting
Diplomatic	Actors with well-honed political antennae who are careful in their use of language
Positive and enthusiastic	These people constantly champion and extoll the virtues and benefits of partnership working
Confident and calm	People who exude good judgement and are firm where necessary

Adapted from Williams (2005)

There is a danger in this context that boundary spanners begin to be viewed as being somewhat superhuman, which is unrealistic. However, this research indeed points to it being a difficult and personally challenging position to hold. Research has pointed out the importance of training to help make boundary spanners more effective. Miller and Stein (2020), when discussing potential future managers in integrated care settings, highlight how important it is they are actively supported and trained for the role and ensure that those already in such positions have time to reflect and learn. However, as Osborne (2010, p. 421) points out, this training is often generic rather than specific to the boundary spanning role:

> '…training has often remained rooted in organisational needs rather than embracing the requirements to develop skills in managing the complex processes of inter-organisational, network and systems governance'.

4.3.2.2 Life Cycle Specific Skills and Roles

The second approach focuses on conceptualising the partnership process in phases or stages in a life cycle. The emphasis on stages is significant when considering PPPs as the literature is clear that this form of partnership almost invariably goes through a life cycle. Boundary spanners must exhibit stage-specific skills and roles as the PPP progresses from establishment to total operational capacity (Williams, 2002, Noble and Jones, 2006). There are a large number of versions of the phases.

Ring and Van de Ven (1994) propose a cyclical network development model that involves a combination of *social* factors and managerial proficiencies. Lowndes and Skelcher (1998) refer to a four-stage life cycle of partnerships. Finally, Kanter (1994) invokes the metaphor of partnership as a marriage. She argues that successful partnerships generally unfold in five overlapping phases: selection and courtship, getting engaged, setting up housekeeping, learning to collaborate; and, changing within. Together, these studies strongly suggest that partnerships go through different development stages that require a set of boundary spanning skills and styles appropriate for different stages. Bamford et al. (2003, p. 186), for instance, asserts that:

> '...an alliance lifestyle has seven distinct stages. The skills sets required from an alliance manager are different in each one of those stages – a visionary is called for at one stage and a facilitator at another'.

In the formation stage of the partnership, Noble and Jones (2006, p. 897) suggest a clear distinction between the roles of 'project champions' and 'boundary spanners'. Project champions are senior management who perform the process of identifying the need to form a PPP. The actions of senior management thereby create the conditions within which boundary spanning managers must subsequently work. Interestingly, they found little in the way of a selection procedure for the boundary spanners they studied. Rather they were 'tapped on the shoulder' by senior managers who considered them best suited for the job, either because of their experience or they were at the proper management level. They found that the

attitude of the boundary spanners in this formative stage was mainly determined not by the amount of cross-sectoral experience they possessed but by the extent to which that experience was positive.

In the implementation stage of the partnership, where the initial contact and negotiations between partners have concluded, Jones and Noble (2008) found that boundary spanners are expected to bring to reality senior management's goals and expectations for the partnership. They discovered that boundary spanners perceive their main professional concern as continually maintaining the forward momentum of the partnership to prevent it from stalling. They found that boundary spanners are aware that the partnership's failure during its implementation stage will mean a substantial loss of organisational resources and credibility. This sense of personal responsibility for the outcome of the partnership put considerable strain on many of the boundary spanners that Jones and Noble studied. They found that boundary spanners are engaged in a constant process of managing the tension between adopting a largely bureaucratic approach (by referring issues to senior management or the partnership board) or resolving issues themselves through informal avenues. The latter option is only possible with an opportunity for trust and commitment building through continual positive interaction.

4.4 Conclusion

It is clear from the healthcare research that internally created boundaries and the subsequent requirement for boundary work can significantly impact how individuals work with colleagues and the impact that this can have on patient care. However, a core tenet of the thesis is that paying attention to organisational boundaries and how they interact has a significant role in whether boundary actors can find shared meaning and hence make a partnership work. Numerous healthcare studies have shown that organisational boundaries in themselves can have an impact. In addition, researchers such as Marchington and Vincent (2004) argue that inter-organisational relationships involve an 'interplay of forces' at different levels (institutional, organisational, and interpersonal). Williams and Sullivan (2009) posit that whilst actors manufacture outcomes, the parameters of their capacity to act – the constraints and opportunities – are set by the structured context within which they operate. Martin et al. (2008) reach a similar conclusion in exploring leadership within

public service networks, arguing that structure provides the 'space' for individual actors to perform and that the relationship between structure and agency is synergistic. Joyner (2007) argues that the potential of PPPs to deliver public benefit rests not only in the decisions and actions of key actors at each stage of the life of the arrangement but also in its effective structuring. Waring et al. (2013) emphasise the importance of looking at both the upstream (structure) and the downstream (agency) level in PPPs that are engaged in frontline or direct public service delivery.

The network perspective of partnership working provides a solid handle to translate the role of leader into boundary spanner. The role and skills of boundary spanners were explored in detail in other literature to ensure that all aspects of the role were covered. Compared to single organisations, leading and managing in partnership is of an order more complicated. Inter-organisational relationships can be horizontal as well as hierarchical (Pettigrew, 2003); trying to solve the paradox of knowing when to lead and when to follow (Connelly et al., 2014); and where governance arrangements may not reflect leadership as it is put into practice (Davies, 2002). The chapter raised the vital point that partnerships may require different skills and attributes of boundary spanners depending on the stage they are at and the kinds of activities being engaged in at that moment in time (Carey and Crammond, 2015). The chapter discussed the four role definitions of the boundary spanner provided by Williams (2012) and found them to describe their primary job.

Having engaged with the organisational boundary literature, it was found to focus either on the internal aspects of each partner organisation or investigate public-public partnerships or private-private partnerships. Therefore, the research significantly underestimates the contrast between a public organisation boundary and a private company boundary and downplays the additional tasks required of boundary actors to overcome the structural impediments between the organisations of the PPP. The thesis aims to rectify this gap in the literature by proposing a new framework that focuses specifically on the boundary differences between the organisations making up the PPP. This framework is the subject of the next chapter.

CHAPTER 5 – THE BOUNDARY WALL FRAMEWORK

The previous chapter concluded that PPP boundaries are more complex than those in a public partnership or a private alliance. Due to the focus of the extant boundary literature on the latter types of partnership, this chapter develops a framework, the 'boundary wall', to reflect these increased difficulties. The chapter frames the boundary wall concept and identifies working propositions that guide the empirical stage of the research. The first section starts by looking at five frameworks that provide insight into the boundary wall. Several themes are common to all frameworks that allow a way of picking out the similarities between them. The key factors are then summarised into three dimensions. The second section links them to wall properties. The final section looks at how the thesis can operationalise the three properties of the boundary wall by selecting the most relevant partnership evaluation tool for the fieldwork data collection.

5.1 Framing the Boundary Wall Concept

Like many other studies that have sought to identify critical characteristics of partnership working, the objective of this section is to produce a framework to aid understanding rather than construct an all-encompassing theory (Asthana et al., 2002). To get an estimation of the potential literature that could help frame the boundary wall concept, research papers that carried out a systematic literature review of PPP implementation were identified (Marsilio et al., 2011, Roehrich et al., 2014, Bryson et al., 2015, Torchia et al., 2015). Their conclusions helped refine what literature was most relevant. Using a suggestion from Dowling et al. (2004), it felt logical to frame the boundary wall as part of the process of partnership working instead of locating it around achieving partnership outcomes. It is also where boundary spanners operate and have the most influence while acknowledging that outcomes are also a crucial aspect of partnerships. There is not much point in partnerships if they don't achieve constructive outcomes. By limiting the scope of analysis in this way, five models that help to codify the concept of the boundary wall were identified. This selection was not based on an exhaustive literature study. Rather they were selected as different ways to illuminate the boundary wall concept. It is not suggested that anyone's theme is more important than any other; instead, it allows for comparison and finds standard features.

5.1.1 Theme 1: Collaborative Processes

Bryson et al. (2015) argue that inclusive processes foster effective cross-sector collaboration and help bridge differences among stakeholders and help partners establish inclusive structures, create a unifying vision and manage power imbalances. They suggest this is done in four ways.

5.1.1.1 Trust

Collaboration partners build trust by sharing resources such as information and demonstrating competency, good intentions, and follow-through; conversely, failing to follow through or serving one's own or organisation's interests over the collaboration undermines trust (Chen, 2010). Often this work is highly personal - in other words, it is about building relationships among individuals, which, in turn, leads to trust among organisations (Lee et al., 2012, Murphy et al., 2012).

51.1.2 Communication

Koschmann et al. (2012, p. 355) note the crucial nature that communication plays, or as they put it, a ‘complex process of meaning negotiation and construction’. In addition, Koschmann et al. (2012, p. 344) argue that where communication is effective, it creates collaborations as ‘higher-order systems that are conceptually distinct from individual member organisations’.

5.1.1.3 Legitimacy

In the context of collaborations, both external and internal legitimacy are critical. For example, non-hierarchical structures and inclusive decision-making processes may not be perceived as legitimate by outsiders more accustomed to traditional command and control bureaucracies. However, both outsiders and collaboration members must see the collaboration as a legitimate entity in its form and interactions (Human and Provan, 2000).

5.1.1.4 Collaborative Planning

Mintzberg et al. (2009) distinguish between deliberate and emergent approaches to planning. Deliberate, formal planning involves careful advanced articulation of mission, goals, and objectives; roles and responsibilities; and phases or steps, including implementation. In the emergent approach, a clear understanding of mission, goals, roles, and action steps emerges over time as conversations

encompass a broader network of involved parties (Koppenjan, 2008, Vangen and Huxham, 2011).

5.1.1.5 Implications

The critical factors from this theme pertinent to boundary wall variation include assessing the inclusivity of the partnership structure, how clear and unifying is the partnership vision and determining whether the power imbalances between the partners are acknowledged and managed.

5.1.2 Theme 2: Conceptualising Process Success

Dowling et al. (2004) carried out an extensive literature review from 1997 examining partnership working. They discerned six process dimensions necessary for partnerships to exhibit to give them the most significant opportunity for success:

- A good level of engagement and commitment of the partner organisations
- Agreement about the purpose of and need for the partnership
- A requirement for a high level of trust and respect between partners
- A benign external environment
- Positive accountability arrangements
- Capable leadership and management of the partnership

Cameron and Lart (2003) conducted a systematic review of the literature around health and social care partnerships and found thirty-eight relevant papers. They distilled the factors that the evidence suggested from these studies promoted or hindered partnership working. They found a high degree of unity across the articles about several factors. They, therefore, were able to classify them into three broad themes: organisational issues (e.g., whether the partnership had clear aims and objectives), cultural and professional issues (e.g., whether the partner organisations trust and respect each other) and contextual issues (e.g., the broader political climate).

In Wildridge et al. (2004) review of the literature on creating successful partnerships, they state that individual partnerships operate within very specific, localised contexts and are dependent on the history of past relationships between the organisations involved. They suggest six key dimensions are required for successful partnership working, including shared vision, trust, communication, decision making and accountability, process and outcomes, and cultural fit. However, they are clear that

the underlying principles behind creating and maintaining a successful partnership are generic irrespective of the organisations involved.

5.1.2.1 Implications

The critical factors from this theme pertinent to boundary wall variation include considering the broader environment in which the partnership is situated, assessing the adequacy of management resources allocated to the partnership, looking at the partners' accountability regime, and considering the cultural fit between partners.

5.1.3 Theme 3: Differential Ability to Partner

In their research exploring public-private collaboration, Bazzoli et al. (1997) draw on the strategic management literature to consider the differential *ability* of organisations to collaborate. They identify financial and human resources, specific technical competencies, and underlying capabilities like information systems as key to an organisations ability to partner. They suggest that strategic management plays an essential role in forming the capabilities of organisations to engage in partnership working and to respond appropriately to changes in the operating environment (Field and Peck, 2004).

5.1.3.1 Implications

The critical factors from this theme pertinent to boundary wall variation include the ability of the partnership management to be strategic, the level of financial and human resources devoted to the partnership, and the technical and managerial capabilities of the boundary spanners.

5.1.4 Theme 4: Critical Success Factors (CSFs)

The concept of CSFs was first introduced by Rockart and the Sloan School of Management (Ismail, 2013). Rockart (1980, p. 04) defined CSFs as ‘those few key areas of activity in which favourable results are absolutely necessary for a particular manager to reach his or her own goals’. Zhang (2005) identified 47 CSFs needed for PPP projects, which he classified into five main aspects of CSFs: ‘economic viability’; ‘appropriate risk allocation via reliable contractual arrangements’, ‘sound financial package’; ‘reliable concessionaire consortium with strong technical strength’; and ‘favourable investment environment’. The author also examined the relative importance of the CSFs based on the perceptions of experts comprising academics and industry players. The results show good agreement in ranking the factors

between the respondents from the industrial sector and those from the academic sector. Trafford and Proctor undertook grounded theory research Trafford and Proctor (2006) discovered five key characteristics that are crucial in ensuring the success of PPP projects: good communication, openness, effective planning, ethos and direction. For the thesis, probably the most relevant research on CSFs is undertaken by The Wilder Research Centre (Mattessich et al., 2001). They analysed the research on partnerships and identified 20 CSFs grouped into six categories. These 20 factors have been created through an extensive review of the literature and are listed below:

Environment

- history of collaboration or co-operation
- the collaborative group is seen as a legitimate leader
- the favourable political and social climate

Membership

- mutual respect, understanding and trust
- appropriate cross-section of members
- members see collaboration as in their self-interest
- ability to compromise

Process and structure

- members share a stake
- multiple layers of participation
- flexibility
- clear roles and policy guidelines
- adaptability
- the appropriate pace of development

Communication

- open and frequent
- informal relationships and communication links

Purpose

- concrete, attainable goals and objectives
- shared vision

- unique purpose

Resources

- sufficient funds, staff, materials and time
- skilled leadership

5.1.4.1 Implications

The critical factors from this theme pertinent to defining boundary wall variation include assessing the following: the environment within which the partnership resides, the process and structure of the partnership, the adequacy of partnership communications, whether the partners have a shared vision and the adequacy of resources.

5.1.5 Theme 5: Tight/Loose Arrangements

Waring et al. (2013) suggest that the thesis view the differences in the relationship between organisations partnering under three areas. The first area relates to the relative level of public and private ‘financing and risk-sharing’, that is, whether the PPP involves primarily private, public or shared financing (Gidman et al., 1995). The second area relates to the level of collaboration in ‘strategic planning and design’, in other words, whether the partners are involved in long-term policymaking or act primarily as external contractors (Hodge and Greve, 2007). The third area relates to the level of 'resource sharing' above and beyond finances, where governance systems, specialist technologies, management capabilities, and human resources are combined (Van Ham and Koppenjan, 2001, Klijn and Teisman, 2003).

5.1.5.1 Implications

The critical factors from this theme pertinent to defining boundary wall variation include reviewing how the partnership has been financed and what risk transfer has occurred, what strategic planning has taken place and how much resource sharing is happening.

To help synthesise the standard features of the themes outlined above, the analysis of Huxham et al. (2000) has proved helpful. They identify three linked dimensions that represent a broad category of issues relevant to the management of partnerships. These dimensions are: ‘managing aims’, ‘managing culture and language’, and ‘managing trust and power’. Looking at the individual dimensions, if a

universal term is applied to each, it is possible to see related areas in the themes discussed. Instead of managing aims, a broader dimension of ‘strategy’ allows for the tie-up of more standard features from the themes’ analysis. The strategy dimension includes how the vision of the partnership is communicated in both formal and informal ways. Instead of managing culture and language, a dimension of ‘culture’ provides a more inclusive definition. Finally, the third dimension, 'managing trust and power', is renamed ‘power’ because the literature on partnership usually portrays trust and power as two sides of the same coin. However, when it comes to coordinating expectations and interactions between organisations (Tomlinson, 2005), power often offers a more realistic managing style for PPPs. Table 12 summarises how the three renamed dimensions allow the similarities between the five themes to be revealed.

TABLE 12: LINKING THE FEATURES OF THE THEMES TO THE THREE DIMENSIONS

Dimension	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Strategy	Create a unifying vision and communicate it	Agreement of purpose	Strategic management	Purpose and Communication	Strategic planning and design
Culture	Establish inclusive structures	Cultural fit	Human resources	Membership	Resource sharing
Power	Manage power imbalances	Accountability arrangements Trust	Financial resources	Resources	Finance and risk-sharing

Own Exhibit

With the three dimensions identified, the thesis visualises them as a wall separating partner organisations. This metaphor takes as its inspiration the New Labour's analogy of breaking down the 'Berlin wall' between health and social care (Department of Health, 1998a). It is postulated that the composition of the wall constrains the ability of boundary spanners to manage the partnership. For instance, if the wall is low, thin and porous, boundary spanners will find little to interrupt the task of managing and communicating between organisations, making the management of the partnership comparatively easy. However, if the wall is tall, thick and impenetrable, there will be a lot of interference to overcome, making boundary spanning tasks complicated to complete. The framework can describe the physical characteristics of the boundary wall using three properties: its height, thickness and density. The framework assigned wall properties to a dimension as the vital aspect of the analogy is to visualise the difference in the overall impact of the wall and gauge how permeable it is. How *high* the wall is dependent on the strategic fit of the organisations; how *thick* the wall is dependent on the cultural fit between organisations; and how *dense* the wall is dependent on the power distribution between partnering organisations. The following section explores these properties in greater detail.

5.2 Three Properties of the Boundary Wall

5.2.1 How High is the Wall?

The thesis conceptualises the height of the wall as a process of strategic goal setting and disseminating in the PPP. The literature on partnerships and private sector alliances usually emphasises the crucial role of goals for creating and maintaining successful collaborations. According to McQuaid (2002), a lack of clear goals is often cited as a significant cause of the failure of partnerships. In addition, Klijn and Teisman (2003) emphasise that PPPs can only thrive if public and private partners desire to find mutual solutions. Cameron and Lart (2003) identified the importance of ensuring that joint working is based on clear aims and objectives, which are understood and accepted by all the agencies and individual professionals involved. The research evidence also emphasised that the aims and objectives of a partnership should be realistic and achievable. Projects that are set up with unrealistic ambitions will almost always struggle to succeed. On the other hand, projects based on practical and possible objectives are more likely to succeed,

particularly if they can demonstrate some early successes, thus enhancing credibility among partners (Hardy et al., 1989).

Swiss (2005) suggests that by their very nature, there is a difference between the goals of private organisations, which are mainly financial and public organisations that pursue more politically complex, mixed, unstable, vague, ambiguous, and often predominantly symbolic objectives. Another conceptualisation suggests that although the public sector's main goals for setting up a PPP might be driven by a collective desire to achieve positive outcomes, PPPs involve organisations from different sectors and institutional logic. As a result, private and public organisations can have diverse and sometimes conflicting objectives. It is possible to distinguish between two types of goals: the individual (independent) objectives of each organisation and the overarching objectives of the partnership. According to Kurr (2004), the partnership objectives are those objectives that both partners accept as the officially stated objectives of the partnership. Individual objectives are those objectives that a particular organisation pursues in a partnership. The personal objectives of one partner can conflict with those of the other partner.

The relationship between the individual, organisational objectives and partnership objectives determines the behaviour of the partners. Kurr (2004) claims that the goals of the individual organisations and those of the partnership can be symbiosis, harmonious or conflict. If no partnership objectives exist, he suggests the purposes of the respective organisations can be complementary, neutral or rivals to each other.

Literature on organisational theory assumes that open communication and a participatory approach to decision-making improve inter-organisational relationships (Huczynski et al., 2013). In their case study on a joint venture for the delivery of corporate and central support services, Trafford and Proctor (2006) note that employees in both organisations tended to assume and also misunderstand the motives of each other. The authors conclude that internal organisation communication and partnership communication are pivotal to facilitating mutual understanding and shared purpose. Wildridge et al. (2004) suggest that the role of clear, consistent communication is at least implicit and often explicit in much of the literature. They highlight that research emphasises different aspects of the

communication spectrum. For instance, targeting specific forms of communication to encourage the involvement of stakeholder groups is crucial (Wilson and Charlton, 1997). Reissner and Pagan (2013) also emphasise the importance of organisational communication activities within PPPs to help generate employee engagement. However, they make the point that it is by no means a straightforward process. Organisations can offer opportunities for employees to experience engagement activities positively, but they cannot force them to engage. The inclusion of service users' perspectives can differentiate between a partnership being taken seriously or not (IPPR, 2001). Partnerships need to ensure they are clear whether they are seeking engagement to inform priorities or simply to keep employees up to date (Audit Commission, 2002). In general, including all affected stakeholders and maintaining positive communications with the constituents of each partnership organisation is of utmost importance (Gray, 1989). The actual act of exchanging information can also enhance the partnership process (Kanter, 1999). On the other hand, poor communication can reduce the effectiveness of a partnership and thus lead to conflict between partners (Jain, 1987).

Geddes (2005) suggests that a successful communications strategy must include the following elements shown in table 13. The process is a significant commitment of time and resources, but Geddes justifies this by pointing out that PPPs have numerous stakeholders requiring their own tailored messages.

TABLE 13: ELEMENTS OF A PPP COMMUNICATIONS STRATEGY

Element	Primary Objective	Primary Target Audience
Personal contact • by chair • by executive director	Political support Resources	Governing bodies of partners Officers of partners
Quarterly reports	Confidence building through successes	Partners
Annual reports	Accountability and political support	All partners and stakeholders
Newsletters and websites	Confidence building	All partners and stakeholders
Public meetings and themed seminars	Confidence building and accountability	All partners and stakeholders

Geddes (2005)

A description of partnership working by Dickinson and Glasby (2010, p. 816) summarises what is at the heart of the height dimension:

> '…the extent to which partnership will be possible in any given situation may well depend on the mix of motives at work in individual partner agencies and the extent to which it is possible to harness these different approaches in pursuit of shared and mutually beneficial outcomes'.

This analysis has led to the derivation of the first two propositions:

Proposition 1: The greater the agreement of partnership aims and objectives by the individual organisations, the lower the boundary wall. Alternatively, the lack of shared goals and objectives between partnering organisations, the higher the boundary wall

Proposition 2: The better engagement and communication to partnership stakeholders, the lower the boundary wall. Alternatively, the less engagement and communication with partnership stakeholders, the higher the boundary wall

5.2.2 How Thick is the Wall?

Reynaers (2014) highlights the stereotypical view of the differences between public and private sector values. The public sector is associated with solidarity and accountability, while efficiency and competition are associated with the private sector. However, she suggests many scholars contest this dichotomy empirically, demonstrating that the border between sectors and their corresponding values is blurred. For example, the Local Improvement Finance Trust (LIFT) programme is a government policy that encourages public and private partnerships to address under-investment in primary care facilities. Mannion et al. (2011) identified several key differences in the values, working practices and cultures in public and private organisations that influenced the quality of joint working. Peck and Dickinson (2008, p.84) suggest that culture appears 'simultaneously to be both an aspiration for partnerships (for example, to change culture) and an obstacle to partnerships (for example, conflicts rooted in culture)'. The literature suggests that this perspective is well-founded and one prevalent when considering the NHS and the private sector working together. Organisations may have such fundamentally different ways of framing issues, reacting to problems and interpreting procedural rules that bringing

such different cultures together leads to a situation of ‘us versus them’ (Marks and Mirvis, 1992).

Although culture is a contested concept with various interpretations based around different epistemological assumptions, most accounts of culture use an *integration model*. Sveningsson and Alvesson (2008) sees culture as something that organisations possess, and which is therefore broadly recognisable and consistent across them. For a partnership to work, the divergent cultures may need to be reconciled and manipulated in relatively predictable ways to enhance joint working.

Meyerson and Martin (1987) proposed a second approach, the *difference model*, which conceptualises culture as more pluralistic, with disparate cultures being held by different interest groups within the same organisation. In this view, culture is an influence that can inhibit partnerships, but where the various cultures may be open to manipulation, particularly concerning how they interact.

The *ambiguity model* is the third perspective of culture discussed by Meyerson and Martin (1987). This model is more local and personal than the other two, with the culture constantly being re-negotiated between individuals and groups within an organisation and between organisations.

To illustrate the potential impact of culture, two PPP arrangements, which the thesis first discussed in chapter 3.4, are used as examples. In a *joint venture*, it is likely that those working in the top management tier of the JV (usually senior managers who originally came from each of the constituent partners) help to create and are personally aligned to its culture. However, significant cultural differences may exist between these managers and those working on the broader organisation, and in the partner agencies, the JV has to interface. The middle management of the JV itself, or the professional, technical and clerical staff transferred, may actively oppose the JV culture on ideological grounds (‘privatising’ the NHS). Both local politicians and the local media may stoke up hostility to it, e.g., because it is 'different to what we do here' or because of the high consultancy fees. In these types of PPP, there is often minimal prior experience of cross-sector working. The willingness to trust partners with very different values, beliefs, attitudes and behaviours can be slow to develop. In *strategic partnerships*, the long-term nature of the deals can arouse hostility in stakeholders who fear inflexibility in the services provided. In addition, shared values

at the initiation stage of the partnership might deteriorate into conflicting values as the stresses and strains of a long term relationship take their toll. In each of the PPP types, a particular cultural gulf faces the private partner. It may have to sacrifice profit for many years in return for the long-term business arrangement with the public authority. It could have to accept behaviours, attitudes, and relationships that it would not tolerate from its internal employee, and it may experience a battering to its reputation at the hands of the media. The analysis above leads to the derivation of proposition 3:

Proposition 3: The smaller the cultural differences between the partnering organisations, the thinner the boundary wall. Alternatively, the greater the cultural differences between partnering organisations, the thicker the boundary wall

5.2.3 How Dense is the Wall?

Rose (1997) highlights that a perceived imbalance of trust and power between partners is often cited as a destabilising factor for those undertaking partnerships. Kanter (1994) notes the management challenge of a partnership can be more complex than operating in traditional hierarchical organisations for several reasons. One of these is that partnerships almost invariably exhibit asymmetrical power relations – that is, one partner holds more power than the other. Literature on partnership working often portrays trust and power as working together to achieve stasis in the partnership. However, according to Bachmann (2001), instead of complementing each other, they are alternative ways of managing relations, meaning it is possible to conceive of two contrasting accounts of partnership. One is more trust focused, and the other is more power-focused.

From a *trust-based perspective*, it is often the absence of trust rather than how much that is the problem. Webb (1991, p. 237) captures this point nicely with his assertion:

> 'Attitudes of mistrust and suspicion are a primary barrier to co-operation between organisations and professional boundaries: collaborative behaviour is hardly conceivable where trusting attitudes are absent'.

Williams (2012) suggests that boundary spanners have an obligation when undertaking their roles to use the medium of trust to enhance the chances of partnership success. However, his research showed that some boundary spanners

potentially treated trust as a tactic to influence others in the absence of alternative forms of power.

A helpful way of perceiving trust from the viewpoint of the boundary spanner is to interpret it through the lens of romantic relationships. Boon (1994) looked at how trust changes over time, which fits well with the idea of a partnership life cycle discussed in chapter 3.2.5. Table 14 refers to three distinct stages in the development of trust – romantic love, evaluative and accommodation and my interpretation of the partnership lifecycle stage are included in brackets.

TABLE 14: A MODEL OF TRUST IN ROMANTIC RELATIONSHIPS

	Stage	Characteristics
1	Romantic Love Stage (initial partnership proposal)	Characterised by 'partners attempt to ensure their best selves are put forward' and in consequence 'expectations about a partner during this stage are little more than tentative theories that speculate, in the absence of actual data, that the partner's feelings and motives are essentially equivalent to their own (Boon, 1994, p. 92)
2	Evaluative Stage (first stage of partnership)	As the breadth of interdependence is assessed, and more information becomes available, 'the continued growth of the relationship is likely to entail some degree of sacrifice, compromise and accommodation' (Boon, 1994, p. 94) as conflicts arise. It is doubtful, however, whether conflict resolution is in practice possible, and a range of issues are raised in circumstances that lead to the failure of trust and where the degree of trust in the relationship falls somewhere between the two extremes of trust and mistrust (Williams, 2012).
3	Accommodation Stage (ongoing partnership working)	'Partners must seek mutually acceptable solutions to arenas of incompatibility and opposing interests exposed during the preceding period of evaluation' (Boon, 1994, p. 95)

Own Exhibit

Some researchers suggest that for a partnership to obtain a high level of trust, communication must involve all actors by negotiating shared meanings and the development of rituals and practices that establish and reinforce shared values, norms, and beliefs (Das and Teng, 2001, Maguire et al., 2001).

Lastly, there is also the important question of how trust can be built up and sustained throughout the partnership. Huxham and Vangen (2013, p. 154) suggest that expectation forming and meeting and successful risk-taking are essential:

> 'Each time partners act together they take a risk and form expectations about the intended outcome and the way others will contribute to achieving it. Each time an outcome meets expectations, trusting attitudes are reinforced. The outcome becomes part of the history of the relationship, so increasing the chance that partners will have positive expectations about joint actions in the future'.

According to a *power-based perspective*, differences among members are seen as conflicting rather than complementary and as highlighting inequalities. Das and Teng (2001) suggest that power issues are inevitable because organisational goals and partnership goals are not necessarily matching. Hardy and Phillips (1998) conclude from a study of contrasting forms of inter-organisational engagement that genuine collaboration was found only where aspects of power were widely distributed among the members. They suggest that more powerful members will show a lack of goodwill towards the participation of lower power participants unless they believe it will serve their interests.

Many authors emphasize the reality of unequal power relations in inter-organisational relationships and PPPs (Hardy and Phillips, 1998, Grimshaw et al., 2002, McQuaid, 2002). Power may cause conflict as one partner seeks to increase his benefit rather than the overall welfare of the partnership. Research indicates that dispute in alliances negatively relates to the effectiveness of the relationship (Bucklin and Sengupta, 1993). In particular, Alter and Hage (1993, p. 186) argue that PPPs are vulnerable to dysfunctional conflict 'because there is no central authority to settle arguments and negotiate settlements' unlike in a single organisation with clear lines of authority. However, if both organisations in a PPP accept the unequal distribution of power, the collaboration will be more successful. In such a kind of collaboration, there are fewer disagreements and strife about objectives and methods between the involved organisations. Hence, the ability of public and private organisations to maintain their partnership is increased either when power is allocated fairly or when unequal power relations are accepted. Alternatively, where power resides overwhelmingly with one

organisation, this turns the partnership's governance into a hierarchy and either this is taken as such by the partnership management, or it is very likely to fail.

This analysis leads to the derivation of the fourth and fifth propositions:

Proposition 4: The greater the trust between stakeholders in the partnering organisations, the more porous the boundary wall. Alternatively, the greater the mistrust between stakeholders in partnering organisations, the more impenetrable the boundary wall

Proposition 5: The smaller the power differential between partnering organisations, the more porous the boundary wall. Alternatively, the greater the power differential between partnering organisations, the more impenetrable the boundary wall

5.3 Operationalising the Boundary Wall

The previous section explored in detail the boundary wall framework. This section extends the analysis by exploring how the boundary wall can be operationalised. The desire to measure the boundary wall fits well with the idea of partnership evaluation which has seen an explosion of interest from academics' keen to assess the success of partnership working. According to Sullivan and Skelcher (2002, p. 185), evaluation of the performance of all forms of service delivery shows:

> '…policy makers' determination to demonstrate real improvement in the well-being of their population and to justify the value added by collaboration'.

Although linking boundary wall measurement with partnership evaluation should broach little controversy, this still brings with it considerable difficulties as the evaluation of partnerships is complex and subject to much discussion from academics (Glendinning, 2002).

5.3.1 Theory of Evaluation

Thomas and Palfrey (1996) highlight the crucial distinction between evaluation and monitoring. Whereas monitoring involves the surveillance of processes and procedures, evaluation is concerned with 'judging merit against some yardstick'. Expanding on this, Rossi et al. (2003, p. 28) commonly used definition of evaluation is:

> ‘The concept of evaluation entails, on the one hand, a description of the performance of the entity being evaluated, and on the other, some standards or criteria for judging that performance’.

Ball et al. (2010) suggest two general approaches to evaluation: theory-lead approaches and method-lead approaches. Theory-lead approaches attempt to map out the process by which the inputs to the partnership lead to the outcome. On the other hand, method-lead approaches try to infer causation from the relationships between inputs and outcomes – which many have named the 'black box' approach.

UK research into partnership evaluation gained impetus in the early 2000s, where New Labour looked for evidence of success in a series of area-based initiatives such as Health Action Zones (HAZs), New Deal for Communities, Neighbourhood Renewal and Sure Start. However, while partnerships were seen as the delivery method of choice, it was not matched with understanding at the local level to effectively implement them in practice (Clarke and Glendinning, 2002). One response to this disparity was to develop tools that enabled local stakeholders (Halliday et al., 2004):

- to reflect on the effectiveness of their partnership
- to describe or ‘benchmark’ its current status
- by focusing on identified strengths and weaknesses to provide a development framework

The two main categories of approaches to meet the above challenges are bespoke and rapid. Tailored responses typically involve an external team of researchers actively engaged in setting up focus groups to obtain feedback from partnership participants, collecting relevant documents and so on. An advantage of this type of approach is the level of engagement and ability of researchers to empathise with partnership participants (Jeffares and Dickinson, 2016). However, this type of approach is almost invariably resourcing heavy and time-consuming and therefore was not considered appropriate for this PhD thesis. An alternative is a rapid approach, and these are generally made up of self-assessment tools. Tsou et al. (2015) undertook a systematic review of articles examining the strengths and weaknesses of partnership assessment tools reproduced in table 15 below.

TABLE 15: STRENGTHS AND WEAKNESSES OF THE USE OF STANDARDISED PARTNERSHIP ASSESSMENT TOOLS

Strengths	Weaknesses/limitations
Helpful in providing 'snapshots' on the strengths and weaknesses of partnership practice (Joss and Keleher, 2011)	Provide little in-depth contextual data to assist the reflection on and evaluation of partnership outcomes (Joss and Keleher, 2011)
Provide easily accessible, cost-effective and straightforward means to measure the essential characteristics of a partnership's work and the collaborative progress during the lifetime of the partnership (Joss and Keleher, 2011)	Generally, inadequately capture the complex, dynamic and context-specific nature of partnership working. Halliday et al. believe that formal tools are open to misinterpretation if used as a 'stand-alone device' (Halliday et al., 2004)
Data obtained can provide a developmental framework for establishing an effective partnership and can be used in all transitional stages of partnership development, including formation (Sunderland et al., 2009)	Overreliance on standardised guidelines and analysis tools may not only deny the complexity and idiosyncrasy of collaborative situations but risk surfacing the tension and exploring the pluses and minuses of alternative ways of addressing issues (Huxham and Vangen, 2004)
Partnership tools can help build knowledge and capacity in local communities that endure beyond the periods of funded program implementation, thereby enhancing the benefits gained from local community partnerships (Sunderland et al., 2009)	Application of partnership tools can be time-consuming
A structured tool can help to discriminate between the performance of different partnerships and also between various aspects of partnership working (Ball et al., 2010)	The need to demonstrate 'value for money' and tangible outcomes for partnerships funded by short term government initiatives can result in the use of an 'auditing tool' to show success rather than supporting ongoing development through the exposure and discussion of partnership strengths and weaknesses (Sunderland et al., 2009)

Tsou et al. (2015, p. 428)

The main criticism of these tools is that they do not provide a comprehensive framework and do not make explicit distinctions between inputs, processes and outcomes of successful collaboration (Asthana et al., 2002). However, as the table indicates, there are many positives to the tools, not least the ability to extract partnership information straightforwardly. Extracting data is crucial as it is likely that

collecting information from the PPP cases will prove difficult from the numerous PPP academic papers read for this thesis.

5.4 Partnership Assessment Tool Review

So which particular partnership assessment tool would best serve the requirement of operationalising the boundary wall concept? Jeffares and Dickinson (2016) state that in the UK context, three of the most widely used approaches are ‘The Partnership Assessment Tool’ (PAT) (Hardy, 2003), ‘The Working Partnership’ (Markwell et al., 2003) and the ‘Partnership Readiness Framework’ (Greig and Poxton, 2001). Unfortunately, the Working Partnership (adapted from the Verona Benchmark) is now not available in a useable format. The Partnership Readiness Framework, although insightful, is not available as a toolkit and therefore must be discounted. Hardy and Hudson's partnership assessment tool is worth further consideration. It is easy to use and, according to Petch (2008, p.08), 'offers useful summary indicator of strengths and weaknesses in partnership working'. Hudson and Hardy (2002) describe how it has been tested in five pilot studies pursuing a range of purposes covering partnerships at different levels of seniority. The PAT has served to define common obstacles to partnership working in health and social care and established that 'partnership principles are generic' applying to different organisational types (Hardy et al., 2000). The criticism of the PAT is that it is predominantly concerned with process issues (Dickinson, 2006). However, as the concept of the boundary wall is focused on the processes of partnership working, this tool is a natural fit.

Essentially the PAT recognises six partnership principles as shown in figure 4. Each principle is explored via six statements or elements, and for each one, the respondent is asked to indicate the degree to which they feel their partnership has secured good practice.

FIGURE 4: THE PRINCIPLES OF PARTNERSHIP

Six key dimensions of partnership:

1. Recognise and accept the need for partnership
2. Develop clarity and realism of purpose
3. Ensure commitment and ownership
4. Develop and maintain trust
5. Create clear and robust partnership arrangements
6. Monitor, measure and learn

Nuffield Institute for Health: Partnership Assessment Tool - Hudson and Hardy (2002)

To obtain some independent reassurance as to the veracity of the claims made by PAT, the researcher applied the methodology suggested by Jeffares et al. (2013), who showed that it is possible to break down toolkits into parts. This form of analysis goes beyond the claim of individual partnership tool authors that their principles are comprehensive and the questions equally weighted. Having studied eight toolkits (including PAT), the researchers derived twelve codes providing composite partnership principles. The twelve principles, according to Jeffares et al. (2013), are:

1. The purpose is clear, aligned and realistic.
2. Availability of appropriate financial and human resources
3. Clarity of motivations, roles, capabilities and contributions
4. Sufficient organisational processes and procedures that foster collaboration
5. Alignment of partners and policies
6. Commitment, ownership and responsibility of partners towards the partnership
7. The partnership is participative and empowering
8. Culture of collaboration, trust and openness
9. Presence (and awareness) of cultural transformation, synergy, efficiencies or exchange
10. Defines success, monitors and reports its performance
11. The partnership is continually engaging with others, developing and learning
12. Clear attribution of benefits, risks and blame

They then looked at each toolkit and showed which proxy measures each one covered in their questionnaires. For example, PAT covers ten of the twelve

dimensions. To ensure that it can measure the boundary wall properties, table 16 below matches PAT's dimensions with the boundary wall's properties.

TABLE 16: MATCHING PAT PARTNERSHIP DIMENSIONS WITH BOUNDARY WALL PROPERTIES

PAT proxy dimension	Boundary wall property
Purpose	Height - strategy
Resources	Denseness - power
Roles	Thickness - culture
Procedures	Thickness - culture
Commitment	Height - strategy
Trust	Denseness - power
Transformation	N/A
Monitoring	Denseness - power
Learning	Thickness - culture
Sharing	Height - strategy

Own Exhibit

The analysis shows that PAT adequately assesses the three boundary wall dimensions and gives confidence that it can be operationalised by including them in my fieldwork. Boundary wall variation occurs where there is an imbalance between the organisations on each dimension: the more significant the inequality, the more substantial the boundary wall. The final physical characteristics of the wall boundary spanners need to breach are determined by adding the differences between organisations across the PAT dimensions.

5.5 Conclusion

This chapter has looked at the concept of the boundary wall. It has shown that it can be framed using three interlinking dimensions and that these dimensions can be thought of as wall properties. Organisations making up a PPP are separated by this boundary wall, whose strength is dictated by the difference in attributes of each organisation. If the wall is low, thin, and porous, the organisations making up the partnership are strategically aligned, have similar cultures, and balance the power distribution. If the wall is tall, thick and impenetrable, then the organisations making up the partnership have different aims and objectives, have different cultures, and substantial power inequality. The thesis proposes that combining these ideas means that PPP performance is not only dictated by the traditional roles and responsibilities of boundary spanners but also by the additional tasks and resources

needed to effectively bridge the boundary wall. The next chapter uses the working propositions developed in this chapter to guide the empirical stage of the research.

CHAPTER 6 – METHODOLOGY, METHODS AND DATA ANALYSIS

This chapter introduces the research methodology and the methods for the data collection and analysis in this thesis. The ontology and epistemology of the thesis are considered first. The former asks how we perceive the world and make sense of it, while the latter asks how we know things (Della Porta and Keating, 2008). Deciding on the answers to these questions are essential as it ensures the thesis has academic consistency and rigour. A comparative case study approach is selected as the research method once the researcher discarded other research methodologies as unsuitable. The limitations of the case study design are outlined, and strategies are discussed to minimise them before the research process is introduced. Hereafter, the research methods - questionnaire, semi-structured interviews, and background documents - are discussed. The data analysis employs coding procedures to operationalise the boundary wall framework.

6.1 Ontology and Epistemology

Recognising the ontological and epistemological grounding for the thesis is crucial. Examining these fundamental attributes provides a conceptual framework to put into context the broad research topic and then offers pointers and consistency to the methods employed to investigate the research questions. As part of exploring the boundary literature to help define the concept for this thesis, it showed that boundaries could be thought of as separating individuals from each other through their beliefs, thoughts and actions. Alternatively, boundaries can be viewed as separating a collection of individuals (termed an organisation in this thesis) from their external environment. The same debate has been at the centre of the discussion over the proper methodology that should be applied to the social sciences stemming from the writings of Max Weber and Emile Durkheim and can be viewed as whether research should be conducted through the individual or the collective lens (Tollefsen, 2014). To answer this question in relation to the thesis, it was helpful to reflect on an example of ontological individualism from an organisation standpoint. Consider for instance an NHS Trust. It remains the same organisation over time even though many of its employees and managers have changed over the years. Therefore, it is not possible to identify the NHS Trust with a particular set of individuals. If we did,

every new employee would mean it would be a different organisation. Ontological collectivism allows for an organisation to be seen as an entity in itself. For instance Searle (1995, p.24) states, 'In my view, all these efforts to reduce collective intentionalism to individual intentionality fail. Collective intentionality is a biological primitive phenomenon that cannot be reduced to or eliminated in favour of something else' and Barley and Tolbert (1997, p. 93) who comment

> 'It holds that organisations, and the individuals who populate them, are suspended in a web of values, norms, rules, beliefs, and taken for granted assumptions'.

Thinking of the NHS Trust example again, it made sense to focus on the organisation as the unit of exploration for the thesis. In addition, it was important to tease out potential values and beliefs of each organisation that had the potential to influence employees by exploring the history of the organisation through documentary analysis which would provide each organisation with its own 'place in history and its own identity' (Lundin and Söderholm, 1995, p. 446). This was crucial in contextualising and understanding the different approaches adopted by boundary spanners to carry out their jobs and responsibilities.

There are two main underlying ways to carry out research. First, the positivists argue that social phenomena can and should be studied through conventional scientific methods, which suggests that all research can be reduced to physical objects and physical laws. In effect, actors are denied the ability to behave subjectively. Second, however, Pawson and Tilley (1997), amongst others, argue persuasively that actors within each organisation perceive and behave differently by the very act of partnering, and this aspect is important to understand and study. Therefore, the research for this thesis is conducted using the interpretive paradigm (which tries to comprehend individual and shared social meanings) with the underlying assumption that the social context of the situation is constructed and interpreted by people (Williamson et al., 2002).

Using the interpretive paradigm to guide the process of conducting the semi-structured interviews meant that it was possible to explore and understand the meanings that key players attach to their actions, roles and circumstances. This felt crucial with a topic so focused on the subjective issues such as trust, culture,

relationships and people's identity. In addition, it encouraged the exploration of the many faceted boundary spanning role, such as using informal discussions to build relationships with key partnership influencers, thereby teasing out organisational influences as well as individual traits and abilities of each boundary spanner.

6.2 Research Design Choice

There is a vast range of research designs that could potentially be used for the thesis research. The suggestion by De Vaus (2001) to think in terms of four broad types of design is adopted to narrow down the field. These are cross-sectional, longitudinal, experimental, and case studies. Each is reviewed in turn to assess their suitability for answering the research topic.

6.2.1 Cross-Sectional Design

Allocation to groups is one of the most crucial aspects of any cross-sectional design because without great care and attention it means problems identifying causal variables will occur. The issue is that even if the two groups differ on an outcome variable - differences in the way boundary spanners go about their work, it is not possible to be sure that these differences are due to a causal link between the variable – the boundary wall. The two groups are likely to differ in ways other than just their partnership status. It has been argued that the very nature of the cross-sectional design can push the researcher's focus onto just looking at the independent and dependent variables rather than seeing the human dimension of the process. As Blumer (1956, p. 869) says:

> 'It leaves out the actual complexities of activity and the actual processes of interaction in which human group life has its being'.

The cross-sectional design could indicate a causal link between the process of partnership and boundary spanner behaviour. However, it will be silent about why there might be this link. By looking at particular aspects of people's beliefs and actions without looking at the context in which they occur, it is easy to misunderstand or misinterpret the meaning of the behaviour.

With the number of variables that are likely to impact the research question, the ability to compare services provided by a partnership arrangement or just by an NHS organisation, the lack of cases hampering the power of the cross-sectional design to

demonstrate a causal relationship effectively, and the inability to look at the human dimension, it is sensible to exclude this type of research design.

6.2.2 Longitudinal Design

In most longitudinal designs, one needs to consider if it should be prospective or retrospective. A prospective design is one where the study is begun now and is then repeated at various points in the future. The retrospective design draws on existing data sets to examine patterns of change up to the present moment. In addition, a choice between a trend and a panel study is required. A trend study entails collecting information from comparable samples but not from the same cases. A panel study collects data from the same cases over time. This type of research design was an attractive option when the fieldwork focused on providing some pathology services. The decision would need to be made as to whether the researcher should follow the same pathology services over several data points to build up a picture at both the individual service level and a general overview of pathology services provided by partnership arrangements and non-partnership arrangements. Alternatively, different pathology services at each data collection could be assessed, which would give a broader view of how pathology is provided around the UK but would likely diminish the insights at the individual pathology service level. However, it became apparent during recruiting research sites that no more than one pathology joint venture was willing to become involved. Only having one JV erected several barriers to using the longitudinal design. First, the researcher received agreement by the pathology joint venture to become involved so late. Thus, it would be almost impossible to collect data over significantly different periods, a vital component of the longitudinal design. Collecting retrospective information about the organisations before the joint venture was also challenging as not only was the information scarce, but it was also seen as confidential and sensitive and therefore unlikely to be easily extracted. Even if the researcher could overcome these hurdles, the fact that he would investigate only one case over time would significantly weaken any suggested generalised findings. Therefore, the researcher decided to exclude this type of research design.

6.2.3 Experimental Design

The classic version of the experimental design would mean constructing the following design to answer the research question. The services that the study was

investigating would be randomly allocated to two different groups. The research would assess the boundary spanner behaviour. NHS/independent sector partnership arrangements would then be applied to one group. The other group or 'control' would continue to provide NHS run services. After an amount of time, the researcher would measure boundary spanner behaviour in both groups. Causal effects would become apparent as the research would remove potential confounding effects through randomisation. However, the researcher can't apply partnership arrangements to one group and not to the other group. The partnership arrangement in all the sites that might agree to participate is an existing difference, and because of this, there can be no random allocation. It is therefore not possible to use this type of research design.

6.2.4 Case Study Design

Considerable research has highlighted the usefulness of a case study design where studies involve investigations into how people interact, engage and talk with each other and how this might change with time, particularly in sophisticated contexts such as healthcare organisations (Pawson and Tilley, 1997, Barley and Tolbert, 1997, Dopson and Fitzgerald, 2005, Dopson et al., 2008, Czarniawska, 2008). Several authors note that the case study method has been the most favoured approach to public management research (Cleary, 1992, Adams and White, 1994, Jensen and Rodgers, 2001). Case studies offer a flexible, time and money efficient approach. They can be instrumental in identifying external variables present in a case and their effect on the partnership arrangement being investigated (De Vaus, 2001). This literature, coupled with the subjectivity of the social mechanisms under analysis and the investigative nature of the research questions, suggests a research design based on case studies using documents, questionnaires and in-depth interviews (Yin, 1994, Anteby et al., 2014). With increased systematic discussion of case study design, their value has been recognised, causing a sharp increase in their use. Significant credit for this must go to Yin (1989, 1993), who has written persuasively about the benefits of case study design. Stake (1995) work has also been influential, particularly in how he allocated case study research into three main types: intrinsic, instrumental and collective. An intrinsic case study is where the researcher is looking for a unique phenomenon. An instrumental case study informs and provides breadth to the researcher about an issue. The collective case study involves several case studies to help bring depth and breadth to the topic under

investigation. In this thesis, the case study is the partnership. The researcher decided on a comparative case study approach as it maximises the amount of data that can be collected from a case study design (Stake, 1995). It is more powerful and convincing and provides more insights than single-case designs (Crowe et al., 2011). In addition, Goodrick (2020) outlines several criteria for a suitable comparative case study design, which this thesis meets.

6.2.5 Comparative Case Study Approach

However, it is important to recognise the potential limitations of a comparative case study design. For example Gorard (2013), is critical of the overuse of the comparative case study as a research design because of their inability to give or make any causal conclusions from a small number of cases. Several issues need to be addressed to counter the potential downsides of the comparative case study design as effectively as possible.

6.2.5.1 Theory Testing

Although some case study researchers conduct case studies as though they only have to collect the facts about each case and engagingly write about them, using a case study design must be guided by theory. In this research, the comparative case study design is used to theory test the research questions that have been painstakingly constructed through the in-depth review of relevant literature.

6.2.5.2 Unit of Analysis

It is crucial to decide the unit of analysis. This thesis tries to build an understanding of the roles of boundary spanners informed by the context in which each case exists. Therefore, it is helpful to use the term Yin (1989) coined to look at the 'embedded' elements of each case. This suggests that the data collection should be at the organisational level, which requires the fieldwork to be broadened beyond administering and analysing the results of the PAT to include semi-structured interviews and relevant documentation.

6.2.5.3 Single or Multiple Cases?

Although it was difficult to get more than one case study to agree to participate, it was important to persevere because multiple case designs are, in most cases, more powerful and convincing and provide more insights than single-case designs (De Vaus, 2001). As multiple case studies are used, it is essential to remember to treat

each case as a separate entity before engaging in cross-case comparisons at the analysis stage (Yin, 1989).

6.2.5.4 Retrospective or Prospective?

The time element is an important consideration and adds to the richness of each case. However, due to the difficulty of obtaining access to these cases, it was not possible to use time as a variable. Nevertheless, it would be worthy of additional research and will be further referenced in the discussion chapter.

6.2.5.5 Parallel or Sequential?

A parallel design is where all the case studies are done simultaneously (e.g., different researchers each doing a case). A sequential design is one where case studies follow one another and, therefore, can be carried out by a single investigator, allowing one case to throw up ideas that can influence the selection of subsequent cases and how the research is conducted. Sequential design is beneficial when an inductive, theory-building approach is being used. It seems the combination of the two will work best in my study. The fact that there is only one investigator means that a sequential pattern of data collection is necessary. However, the researcher will treat each case independently. The results will only be analysed after all the data has been collected, so there is no influence to change the data collected through the fieldwork. This method will allow for a much more rigorous theory testing regime.

6.2.5.6 Time Pressure on Participants

The case studies are likely to place a time burden on participants, increasing sample attrition and loss of data quality. Furthermore, while material incentives can help maintain participation, it would not be appropriate for this fieldwork as the NHS forbids any financial inducements. An alternative, as De Vaus (2001, p. 139) points out:

> '…probably the most effective incentive is for people to feel that their participation is both important and constructive'.

Dillman (1978) emphasises that the overriding goal should be to make participation in the study a positive experience rather than an unwelcome burden and intrusion. This recommendation will be kept in mind when creating the literature and interviewing the participants.

6.2.6 Strengths/Limitations of Comparative Case Study Design

The above section has shown that the comparative case study approach is beneficial when an appreciation of an issue is required in its natural, real-life context. To maximise its usefulness, vital methodological considerations need to be considered about the design, analysis, interpretation and reporting of the comparative case study design. The researcher reviewed the ontological and epistemological standpoint of the thesis to ensure that it was compatible with the comparative case study design. Although the review of alternative research designs has shown that the comparative case study design is potentially less rigorous, it is possible to maximise the ability to achieve broader generalisations from the specifics of each case with careful thought and planning. To accomplish this is the subject of the next section.

6.3 Research Methods

The previous section confirmed the selection of the comparative case study design used for theory testing the research questions developed through interpreting the research outlined in this thesis. To heighten the study's validity and gain a rich picture of the cases, Yin recommended that information triangulation be applied by collecting multiple data sources (Yin, 1994). During the empirical stage of the research project, three data collection methods were employed: first, background documents to provide the context of each case study; second, a questionnaire to provide quantitative information; and third semi-structured interviews to provide qualitative data and additional contextual information cross-referencing the questionnaire.

6.3.1 Documents

Goode and Hatt (1952) stress the importance of looking at a case study within the whole context. This emphasis on looking at the context is picked up by Yin (1993, p. 31), who argues that:

> ‘A major rationale for using [case studies] is when your investigation must cover both a particular phenomenon and the context within which the phenomenon is occurring’.

This emphasis is significant because behaviour occurs within a context, and its meaning stems mainly from that context. Therefore, it is essential to understand the

operational environment within which the boundary spanners are carrying out their jobs.

One way to help build a picture of the environment is to collect as many documents pertinent to each partnership as possible and then analyse them. This should provide helpful information about the historical and current context within which each boundary spanner operates. In addition, taking any unique circumstances into account when concluding should increase the study's internal validity. A document is a written, audio or visual record (Bowling, 2009). The advantages of document research include their relative non-reactivity with the researcher, convenience and low cost compared to other research methods (Bowling, 2009). However, some researchers have expressed scepticism about the extent to which documents can view as unbiased sources. For example, May (2001) noted that documents might employ unexamined assumptions about the case, which the researcher could accidentally reproduce.

One benefit of including NHS organisations in the case studies is that they have a statutory duty to publish documents outlining their ongoing strategic drivers and historical performance data. These documents are available on their respective websites and were downloaded and analysed as part of each case study. These documents included minutes of board meetings. On the face of it, minutes are a record of the issues and information presented at each meeting, the discussion of those issues, views of participants and actions assigned. Thus, they have the potential to reveal things about the organisation culture, its preoccupations and possible disputes between board members. However, precisely because the minutes are a document put in the public domain, they are likely to be written with this scrutiny in mind. Disagreements may be suppressed, and sensitive information not recorded. Rather than view documents as ways of gaining access to an underlying reality, writers such as Atkinson and Coffey (2011) argue that documents should be viewed as a discrete 'reality' in their own right. The researcher should consider the documents in the context in which they were produced and the audience. They are written almost invariably to convey a positive impression of the authors and the organisation. Their central point is that documents need to be recognised for what they are – namely, texts written with specific purposes in mind and not simply reflecting reality. The collection of specific private company partnership documents

was not so satisfactory. There was only a small amount of publicly available information for each private-sector partnership participant. Although having gained permission to interview employees of these companies, it was impossible to obtain or use any documents, not in the public domain.

TABLE 17: LIST OF BACKGROUND DOCUMENTS

No.	Document Name/Type	Document Description/Title	Case study	Authored by
1	Board minutes	October 2017	WOS	Trust 2
2	Board minutes	December 2017	WOS	Trust 2
3	Board paper	December 2017	WOS	Trust 2
4	Letter	Creation of a New Subsidiary Company of Trust 2 (WOS) – 20/12/2017	WOS	Trust 2
5	Annual Report	Trust Annual Report 2017/18	WOS	Trust 2
6	Website	UNISON press release – 22nd December 2017	WOS	UNISON South
7	Website	Hundreds of NHS staff forcibly moved to a private company, says UNISON 07/02/2018	WOS	Nursingnotes.co.uk
8	Annual Report	Trust Annual Report 2018/19	WOS	Trust 2
9	Briefing document	What are wholly owned subsidiaries – 26/06/2018	WOS	NHS Providers
10	Consultation document	Consultation on our proposed extension to the review of subsidiaries – October 2018	WOS	NHS Improvement
11	Consultation document	Proposed extension to the review of subsidiaries: consultation response – November 2018	WOS	NHS Improvement
12	Article	Guidance for wholly-owned subsidiaries sets the bar too high – 26th November 2018	WOS	Cordery (2018)
13	Press Release	Hospital IT success goes global	IT	Press Release (2016)

		08/09/2016		
14	Magazine website	Case study: Achieving clinical credibility in NHS IT projects 11/08/2016	IT	NHS Boundary spanner – building better healthcare
15	NHS Report	Report of the Review of NHS Pathology Services in England 06/08/2006	PATHOLOGY	Carter (2006)
16	NHS Report	Report of the second phase of the review of NHS pathology services in England 2008	PATHOLOGY	Carter (2008)
17	HSJ Article	Lord Carter's pathology review is more relevant than ever 17/12/2013	PATHOLOGY	Critchard (2013)
18	British Journal of Healthcare Management	Our pathology services in England fit for purpose 2013	PATHOLOGY	McGauran (2013)
19	NHS England	NHS Improvement pathology networking in England: the state of the nation	PATHOLOGY	NHS England (2017)
20	Movie	Lord Carter speech at the opening of the Pathology Hub Laboratory May 2013	PATHOLOGY	Private company

Own Exhibit

6.3.2 Questionnaire

The researcher decided to run a pilot case study to test out the method of delivery of the questionnaire because, as Bryman (2012 p. 263) argues:

> 'Pilot studies may be particularly crucial in relation to research based on the self-completion questionnaire since there will not be an interviewer present to clear up any confusion'.

The pilot was not carried out on people going to be included in the final case study analysis. Instead, a small set of respondents should be selected, similar to the

population from the study sample (Bryman, 2012). Before talking to the respondents in the pilot, the researcher sent them an information sheet outlining the research aims. It confirmed the researcher would only use the information they provided for research purposes. It also highlighted the benefits of participation which included:

- It will provide an established Partnership with the opportunity to 'health check' their partnership arrangements
- It will help a newly formed Partnership by providing a developmental framework for establishing a healthy and effective partnership by, amongst other things, highlighting what to avoid
- The researcher will write up the results of the fieldwork in a confidential report which will offer a common language for partners to discuss both the opportunities for developing more effective working and the perceived barriers to this happening
- The research will add to the body of literature looking at public-private partnerships
- The research will be conducted by an experienced HR professional and business owner who will ensure sensitive implementation of the fieldwork requirements

In the pilot, the researcher discussed the completion of the questionnaire at the end of the telephone interview. He described the use and purpose of the PAT in detail, and each participant was asked to confirm that they were happy to complete it. After asking if the participant had any questions, the researcher ended the conversation. In the follow-up email, a covering letter was attached. The letter was written on University of Birmingham headed paper, contained their name and address, outlined the study aims and benefits, guaranteed confidentiality, and was signed in blue ink to personalise it. It also thanked them for their time and included a unique link to the PAT. Although created as a paper-based questionnaire in 2002, consideration was made to administer the PAT online as the technology for transferring this type of questionnaire online is now so advanced it is possible to replicate them for online use. Research by Evans and Mathur (2005) discuss several significant strengths and weaknesses associated with online surveys. On the positive side, they highlighted the flexibility of the online format, ease of administration, data entry and analysis,

and low administration costs. On the negative side, they point out that being online can bring a perception of junk mail, it can be subject to unclear answering instructions, it can be seen as impersonal, and there is generally a low response rate. As the PAT was only going to be sent to respondents who had already been spoken to, the disadvantages of online administration seemed to be significantly reduced. The potential positives substantially outweighed them.

The researcher decided to administer the PAT online and used the software package ‘Qualtrics’ to do this. A survey designer had to learn to program and write code in HTML to create a survey in the past. Using Qualtrics meant creating and launching an online survey became easy. It provided flexibility in question type, format, response categories, layout, fonts and visual aspects. It also offered flexibility in terms of automatic logic control, branching, randomisation of questions if required. In addition, the programs provide flexibility in restricting/eliminating invalid responses (Evans and Mathur, 2018). Although having not encountered the package before, translating the PAT to an online environment was self-explanatory and quite time-consuming. It was important to ensure that the participants understood the purpose of each section and the context of each question in the area, which required extensive written explanations.

One significant advantage of using this type of package is the analysis suite. It meant that every conceivable metric was measured from how long it took to fill out the questionnaire to where in the questionnaire the participants paused. How soon the participants would access the PAT to fill it out was overestimated, so new unique links had to be sent out as a number of them had expired before the participant had accessed the PAT. The researcher chose this online method as the data could be collected and collated very quickly. It didn't require the researcher to meet the research participant, which in some cases was hundreds of miles away. It was also seen as the most convenient way for the participants to access and complete the PAT. The first case study to go live was the hospital group, and the researcher took several boundary spanners through the process. The first part of the process worked well, with all identified boundary spanners from the partnership finding time to participate in the telephone interview. They were all sent a unique link to fill in the questionnaire within an hour of concluding the telephone discussion. After reminders to all five telephone interview participants had been sent out and only one participant

subsequently completed the questionnaire, it was clear that there was a problem using this method, and an alternative needed to be found.

There has been a lot written about the characteristics of the three alternative ways to administer a questionnaire: the mail questionnaire, the personal questionnaire and the telephone questionnaire (Dillman, 1978, Alreck and Settle, 1994). In discussing the three methods in the second edition of their book, Alreck and Settle (1994) note that personal interviewing offers the best opportunity for positive contact and interaction between interviewers and respondents. Therefore, the researcher decided that filling out the questionnaire needed to form part of the interview process. The participant completed the PAT at the end of the semi-structured interview. The researcher read out each question, and the respondents were asked to grade the answer from 4 (strongly agree) to 1 (strongly disagree). There were six questions per principle and six principles in all. In addition, there were two summary questions at the end. The first asked the interviewee to highlight, if appropriate, any of the six principles that were particularly significant in their partnership. The second summary question asked the interviewee to rate on a scale of 4 to 1 whether the partnership was currently achieving its aims and objectives. Completing the PAT at the end of the interview had an unexpected bonus. Due to the interview, the boundary spanner had already thought about the partnership. Thus, it felt like a natural extension of the process rather than a chore.

6.3.3 Semi-Structured Interviews

The semi-structured interview typically refers to a context in which the interviewer has a series of questions in the general form of an interview schedule but can vary the sequence of questions (Bryman, 2012). Semi-structured interviews were chosen as a primary data source because this method was best suited to access boundary spanners' interpretations about their job roles and activities in the PPP. Primary data are new data explicitly collected for the research purpose (Thornhill et al., 2009). Semi-structured interviews aim to discover the respondent's point of view (Bryman, 2012). This aspect is of particular interest because what issues and concerns are identified as being part of the job of the boundary spanners depends on the individual's interpretation of the context. The thesis applied semi-structured interviews because it allowed some latitude to ask further questions in response to exciting or significant replies. A list of topics based on the research questions served

as a template during the semi-structured interviews. These are outlined in table 18 below.

TABLE 18: SEMI-STRUCTURED INTERVIEW GUIDE

Number	Topic
1.	Background and how you became involved in the partnership
2.	Current role and responsibilities in managing partnership
3.	How has this changed since you started the role?
4.	How will the role change in the future?
5.	Who else is involved in managing the partnership?
6.	Completion of the PAT

Own Exhibit

After the pilot telephone interviews, the decision was made to interview the boundary spanners face to face because the researcher can then observe face and body language. Moreover, this type of interview tends to be longer and more fruitful than telephone interviews (Shuy, 2002).

It was recognised that time and effort needed to go into preparing for each interview. In particular, the researcher put thought into ensuring that he would ask questions in a non-biasing and non-leading way. Before the interview, the respondent was sent a participation information sheet. The researcher thanked them for participating in the study; he provided them with a synopsis of the research aims; their information would only be used for research purposes and not used to identify individual responses. At the end of the study, it noted that anonymised research data would be archived at the UK Data Archive to make it available to other researchers in line with current data-sharing practices. Furthermore, it confirmed they could withdraw from the study, with a written request, within six months of taking part and would not be asked many questions about why they no longer wished to participate. Finally, it noted that the study had ethical approval from the University of Birmingham.

At the start of the interview, the researcher found a convenient place to conduct the interview. The room ranged from respondent's private offices, a meeting room and the organisations' café, which luckily was nearly empty. The researcher told them that a recording device was being used right from the start, and he sought their prior

permission. Every interviewee agreed to being recorded, although a couple needed reassurance that the contents were strictly confidential. In each interview, the interviewer built a rapport with the respondent, which meant that the discussion could be conducted relaxed and positively. As the Survey Research Center (1976) recommended, gentle probing was sometimes used to clarify and enlarge upon their answers. In general, it was easy to extract information with little prompting. The respondent was given leeway as to how they decided to answer each topic, and this was reflected in the variety and length of responses gained from each boundary spanner. As Bryman (2012, p. 487) suggested, the interviewer kept on the recording device after completing the PAT as it is sometimes the case that interviewees 'open up' at the end of the interview. This happened to the interviewer who obtained additional comments about the partnership while running through the PAT, which added to the data that he could analyse.

6.4 Data Analysis

6.4.1 Analysis of Documents

Qualitative content analysis is the basis by which data from the documents have been extracted. Content analysis was a term used by Altheide (1996), who suggests a practical approach to analyse documents is for the researcher to construct the meaning from the documents by allowing categories to emerge from the data and to recognise the significance for understanding the importance in the context of the whole document being reviewed. This method is used to examine each document for underlying themes, and quotes illustrate the most relevant. The focus of the data extracted from the case study documents is on each document's social and cultural context and its production. They are used to add flavour and depth to the more subjective case study information collected and gain an initial understanding of the organisational setting, prepare for interviews and add depth to themes from the interviews.

There are several advantages to qualitative content analysis. First, it is a very transparent research method. The results chapter sets out how the information is extracted from the documents, allowing for replication and follow-up studies. Second, it provides a level of longitudinal analysis as it has been possible to find relevant documents over an extended period for some of the case studies. Third, it is an

unobtrusive method (Webb et al., 1966) which means that the researcher does not influence how these documents were produced, reducing the potential for bias to creep in. Finally, it is flexible, allowing the researcher to apply the method to all documentary evidence collected for the case studies. However, it is acknowledged that the reliability and validity of these documents are rarely perfect, meaning that when used for this research, the themes extracted from the documents are cross-checked with other supporting sources of data.

6.4.2 Analysis of Questionnaire

6.4.2.1 Overall PAT Score

Once the respondent had completed each PAT, analysis is generated by following the recommendations laid out by Hardy et al. (2003, p. 42):

> 'The individual scores for each principle should be totalled to give an aggregate score (within the range 144 - 36) for each partner'.

This provides data that, when manipulated, indicates how substantial the boundary wall is between partnership organisations. To demonstrate how the numbers generated by the PAT are used to derive the strength of the boundary wall, an example is set out below:

TABLE 19: DERIVING THE STRENGTH OF THE BOUNDARY WALL

Case study	NHS boundary spanner score	Private boundary spanner score	Boundary wall
PATHOLOGY Trust 1	89	116	27
PATHOLOGY Trust 2	93	116	23
IT	128	127	1
WOS	133	117	16

In the PATHOLOGY case study, there are three organisations involved, two NHS Trusts and a private company; hence there are two boundary walls. Take the PATHOLOGY case study as an example: 116 (private boundary spanner score) – 89 (NHS boundary spanner score) = 27 (boundary wall). There is an assumption that the divergence matters, not whether the NHS or private boundary spanner has the

higher score. The greater the degree of variation in overall scores, the more substantial the boundary wall.

6.4.2.2 Individual Properties of the Boundary Wall

It is possible to increase the granularity of PAT analysis by combining the scores from two sections that measured the same property of the boundary wall. This process was carried out for all six principles, resulting in sections that equate to the boundary wall's three properties. How the researcher combined, the principles are shown in table 20 below.

TABLE 20: SIX SECTIONS OF PAT ALLOCATED TO THE BOUNDARY WALL PROPERTIES:

Principle of PAT	Boundary wall property
1. Recognise and accept the need for partnership	Thickness
2. Develop clarity and realism of purpose	Height
3. Ensure commitment and ownership	Thickness
4. Develop and maintain trust	Denseness
5. Create clear and robust partnership arrangements	Denseness
6. Monitor, measure and learn	Height

Own Exhibit

Sections 2 and 6 of PAT dictate the height of the wall and inform the first two propositions, which were derived in chapter 5.2.1:

Proposition 1: The greater the agreement of partnership aims and objectives by the individual organisations, the lower the boundary wall. Alternatively, the lack of shared goals and objectives between partnering organisations, the higher the boundary wall

Proposition 2: The better engagement and communication to partnership stakeholders, the lower the boundary wall. Alternatively, the less engagement and communication with partnership stakeholders, the higher the boundary wall

Sections 1 and 3 of PAT dictates the width of the wall and inform the third proposition, which was derived in chapter 5.2.2:

Proposition 3: The smaller the cultural differences between the partnering organisations, the thinner the boundary wall. Alternatively, the more significant the cultural differences between partnering organisations, the thicker the boundary wall

Sections 4 and 5 of PAT dictate how dense the wall is and inform the fourth and fifth propositions, which were derived in chapter 5.2.3:

Proposition 4: The greater the trust between stakeholders in the partnering organisations, the more porous the boundary wall. Alternatively, the greater the mistrust between stakeholders in partnering organisations, the more impenetrable the boundary wall

Proposition 5: The smaller the power differential between partnering organisations, the more porous the boundary wall. Alternatively, the greater the power differential between partnering organisations, the more impenetrable the boundary wall

To demonstrate how the individual properties are calculated, the table below shows an example of the Trust 2 PATHOLOGY case study.

TABLE 21: INDIVIDUAL PROPERTIES OF THE BOUNDARY WALL

Section/wall property	Dimension	NHS Trust 2 BS	NHS Trust 2 Total	Private BS	Private Total	Boundary wall score
1 – How thick?	Culture	16	**35**	19	**38**	**3**
3 – How thick?	Culture	19		19		
2 – How high?	Strategy	17	**31**	20	**40**	**9**
6 – How high?	Strategy	14		20		
4 – How dense?	Power	13.	**27**	19	**38**	**11**
5 – How dense?	Power	14		19		

This shows that it is possible to break down the overall boundary wall score of 23 for Trust 2 into the three boundary wall properties: 3 (how thick/culture) + 9 (how high/strategy) + 11 (how dense/power) = 23 (overall boundary wall score) as calculated in the previous section.

6.4.3 Analysis of Semi-Structured Interviews

Heritage (1984, p.238) suggests that the procedure of recording and transcribing interviews has the following advantages:

- ‘It helps to correct the natural limitations of our memories and of the intuitive glosses that we might place on what people say in interviews
- It allows a more thorough examination of what people say
- It permits repeated examinations of the interviewees’ answers
- It opens up the data to public scrutiny by other researchers, who can evaluate the analysis that the original researcher of that data carries out
- It, therefore, helps to counter accusations that a researcher's values or biases might have influenced analysis
- It allows the data to be reused in other ways from those intended by the original researcher’

On the negative side, it is recognised that the procedure is arduous and very time-consuming as well as the recording equipment can be off-putting for respondents. Despite these downsides, the researcher decided to systematically record and transcribe the interviews to code them in the most accurate possible way. In addition, the interviewer was able to record the interview using a smartphone which made the process unobtrusive. Becker et al. (2002, p. 211) suggested that it is possible to ignore some parts of the interview for transcribing purposes to save time and effort as some qualitative interviews are 'uninspiring and uninteresting'. However, the researcher decided against this because it was clear that even when sections did not provide coded data, they still revealed how the boundary spanner was processing the question. Moreover, it helped with understanding the overall context of the role and actions of the respondent.

6.5 Coding the Transcripts

Data collected from the semi-structured interview fieldwork was analysed by qualitative methods (Huberman and Miles, 1994). As with many case studies, the research process logic and the data analysis is influenced by grounded theory that emphasises the importance of not starting with too many preconceptions. Glaser and Strauss (1967) book 'The Discovery of Grounded Theory: Strategies for Qualitative Research’ is the chief architect of the approach and is one of the most widely cited

books in the social sciences. Yet, the process has been open to much interpretation, not least because the authors developed grounded theory along different paths. What is not in doubt is that coding the data is one of the most central processes in grounded theory. Charmaz (2006) usefully distinguishes between two primary forms of coding: initial coding and focused coding. Focused coding entails emphasising the most common codes and those seen as most revealing about the data. The coding process started by reading through the transcript of each semi-structured interview to get a feel for the main points raised. On re-reading the transcripts, they are helpful not only to understand the different roles and activities of the boundary spanner, but many comments from the boundary spanners add context and clarity to the properties of the boundary wall, whether consciously or subconsciously. In addition, the transcripts have shed light on other aspects of case studies. These are as follows:

6.5.1 Case study background

Although document analysis has been the primary source of putting each case study into context, comments by each boundary spanner have been helpful to back up or cast doubt on what the documents reveal. The most applicable quotes are provided in the results chapter, with comments and analyses found in the discussion chapter.

6.5.2 Selection and Continuing Professional Development of Boundary Spanners

As discussed in chapter 4, the essential job of the boundary spanner is to try and persuade people to carry out requests that they may not be inclined to follow and without the hierarchical power to insist. This puts a significant onus on the personal attributes that boundary spanners bring to the job. Williams (2012) suggests that their skills (technical and interpersonal), knowledge of particular areas of expertise or accumulated knowledge from carrying out the role for a while, and their previous work history likely influence how the roles are performed. To test this, the research analysed each transcript for how the boundary spanners were selected, their previous work experience, and any training received before, on appointment to the job, and continuingly.

6.5.3 Boundary Wall Properties

The coding methodology highlights where the boundary spanner talks in either positive or negative terms about the different properties of the boundary wall. The initial codes were created by synthesising the analysis of the three properties of the boundary wall outlined in chapter 5.2. They were then applied to the transcripts. The researcher found that additional codes were needed to fully match what the boundary spanner said with the dimension used in the focused coding. These different codes have been highlighted in red. Codes were quite broad to keep their application as straightforward as possible. The researcher did all the coding manually.

TABLE 22: CODES USED FOR BOUNDARY WALL TRANSCRIPT ANALYSIS

Initial positive/negative coding (using section 5.2)	Focused coding – using four colours
Clear / unclear goals Partnership objectives shared/conflicting Partnership objectives realistic/unrealistic Organisation objectives complementary/neutral/rivalling Open communication/poor communication Participatory decision making/hierarchical decision making	Strategy dimension How high is the boundary wall?
Positive/negative interactions between partners Positive/negative behaviour between partners Positive/negative attitude between partners Positive/negative relationships between partners	Culture dimension How thick is the boundary wall?
Partnership benefit/organisation benefit Partnership interest/organisation interest Predictable/unpredictable behaviour Wide distribution of power/focused distribution of power Positive/negative view of shared risk Positive/negative view of contract	Power dimension How dense is the boundary wall?

History/no history of collaboration or cooperation Positive/negative political and social climate Legitimate/contentious partnership	Environment How stable are the boundary wall foundations?

Own Exhibit

The coding highlights in different colours where the boundary spanner talks about the other properties of the boundary wall. The researcher highlighted statements about the height of the wall (strategy dimension) in yellow; he highlighted comments about the thickness of the wall (culture dimension) in green; he highlighted comments about the denseness of the wall (power dimension) in pink, and he highlighted words about the environment in blue. This was a helpful visual clue to see the main focus of each boundary spanner (see appendix 1 for an example).

6.5.4 Coding the Granular PAT

To help flesh out the qualitative research, the researcher interrogated the transcripts to extract positive and negative comments about the wall, which enhances understanding of where the numbers from the PAT have been derived.

6.5.5 Boundary Spanner Roles and Activities

The coding highlights all the different roles taken on by the boundary spanner when answering questions from the semi-structured interview. How to code this section has been inspired by the work of Williams (2011, p. 27):

> 'The individual elements of the boundary spanners' role are deployed in different permutations depending upon the nature of the challenges faced and the tasks involved'.

This mirrors the thesis premise that partnerships function differently depending on the boundary wall and that these differences reflect how boundary spanners behave to ensure the partnership is as effective as possible. To test this premise, the researcher analysed each transcript and every time the boundary spanner displayed a particular role, he highlighted it. Then, using the suggestions of Williams (2012), he looked for four role elements most commonly employed by boundary spanners. Finally, to help with the analysis, the researcher used the words describing the main competencies attached to each role to ensure that he could thoroughly interrogate the transcripts. These words are displayed in table 23 below.

TABLE 23: ROLES AND COMPETENCIES OF BOUNDARY SPANNERS

Role	Main competencies
Reticulist	Networking, political sensitivity, diplomacy, bargaining, negotiation, persuasion
Interpreter/communicator	Interpersonal, listening, empathising, communication, sensemaking, trust-building, conflict management
Coordinator	Planning, coordination, servicing, administration, information management, monitoring, communication
Entrepreneur	Brokering, innovation, whole systems thinking, flexibility, lateral thinking, opportunistic

Adapted from Williams (2012, p. 58)

6.6 Selecting Cases for a Multiple Case Study Approach

Before selecting cases for the fieldwork, it was essential to think through what base criteria should be used. The external validity of case studies is enhanced by the strategic rather than statistical selection of cases (De Vaus, 2001). There is no correct number of cases to include in a case study design. A significant factor in determining the number of cases is the rigour in which the proposition is to be tested. Using the logic of replication, a single replication tells the researcher something, but repeated replications give more confidence in the findings. Not all writers are convinced about the merits of multiple-case study research. Dyer and Wilkins (1991) argue that a multiple-case study approach means that the researcher pays less attention to the explicit context and more to how he can compare the cases. Taking this concern on board, the researcher still felt that obtaining results from partnerships variously situated along the partnership spectrum (as outlined in chapter 3) would significantly enhance the findings. Therefore, the researcher adopted a multiple-case approach and concentrated on getting as many relevant cases as possible in the allotted time frame.

The process of finding suitable sites was much more complicated than anticipated. As pointed out in chapter 2, PPP use in the NHS has significantly diminished in the years since the researcher started the PhD in 2012. Having reviewed significant amounts of policy and practice literature, the first approach was to several well-networked individuals the researcher contacted to help identify potential cases.

The first individual was a senior officer of Care England (which represents independent care providers). Throughout a telephone conversation, the officer expressed great interest in the thesis topic. The officer felt that the majority of members had contractual relationships with NHS organisations rather than partnerships. The officer offered to put out a request to members to ask for expressions of interest. The officer confirmed that he had sent the request in many follow-up emails but that no organisation had responded.

The second individual to be contacted was an NHS Partners Network officer (part of the NHS Confederation and the representative body for independent sector healthcare providers). Throughout a telephone conversation, the officer noted a significant decrease in partnership activity between the NHS and the independent sector. This was mainly due to the costs and expertise required by NHS organisations to set up a partnership arrangement that NHS England was not now subsidising. The researcher asked if he could identify two cases that either involved a joint venture or a partnering contract that involved changing service delivery in some way. Although expressing optimism, over six months of email correspondence, it became clear that the officer could not get any traction from his members.

The third individual contacted was an NHS Engagement Partner Officer of the Association of the British Pharmaceutical Industry (ABPI) - which represents the interest of pharmaceutical companies who have several joint ventures with NHS organisations. The officer was very generous with his time on the telephone and talked about projects that were either currently happening or had just finished between NHS organisations and individual pharmaceutical companies. The officer noted that it was now much more common for joint work between an NHS organisation and multiple pharmaceutical companies. This stopped any accusations of influence-buying that had undermined some joint working initiatives. The officer agreed to send out a request to his members for expressions of interest to become involved with the study. Unfortunately, after some chase up calls and emails, it was concluded there was minimal membership interest.

Some other leads were followed up, such as the muscular-skeletal partnership in Brighton. Although the researcher sent many emails to the NHS contact, it was never possible to find a time to talk. The IT community-based company manager in

Somerset was interested but felt that he would not have time to be interviewed. The managing director of a private company with several pathology partnerships with NHS organisations was initially keen to be involved. Subsequently, he decided it would be too disruptive and time-consuming management time as the company was engaged with bids for numerous new contracts (which have not been successful).

However, after using numerous personal contacts and deciding to 'stretch' and 'loosen' the initial tight definition of PPPs to include private companies contracted by the NHS to provide a service or increase capacity in the system, it was possible to engage three cases. A description of each is provided in the next section.

6.7 Case Study Description

6.7.1 PATHOLOGY Case Study

In his second phase, independent review for the Department of Health completed in 2008, Lord Carter (2008) recommended that pathology services be reconfigured to improve quality and efficiency across the system. Pathology touches almost every patient, and although usually sited in the secondary care (hospital) setting, it also provides services to primary care (GP services). It encompasses everything from a simple blood test to complex diagnostics that determine suitability for ground-breaking drugs. The recommendations by Lord Carter have been interpreted in different ways across the country. Some pathology services have chosen to continue their current structure; others have chosen to merge with neighbouring pathology services, while others have chosen to partner with the independent sector.

This case falls into the latter category. The pathology partnership is a joint venture between two Foundation Trusts and a private sector partner. The partnership delivers complete laboratory services to a population of 500,000 patients and over 100 GP practices. Respondent 1 – Snr Mgr Pathology is the boundary spanner for the private company. He actively set up the pathology partnership in 2011/12 utilising his extensive knowledge and skills in pathology information technology and testing repertoires across the organisation. The boundary spanner has over 25 years of experience working as a Biomedical Scientist. He was instrumental in setting up interviews with the boundary spanners from the two NHS foundation hospitals, the other organisations involved in the partnership.

NHS Trust 1 is a major hospital in the South of the country, which serves a market town and its surrounding areas. It serves a population of over 300,000. Respondent 2 – Mgr NHS Trust 1 is the boundary spanner for the Trust. She has worked in the NHS her whole career in various locations before recently returning to the hospital.

NHS Trust 2 is a single site Foundation Trust. They provide a full range of clinical services – including general medicine, cardiology, general surgery, orthopaedic surgery, trauma and paediatrics. Respondent 3 – Mgr NHS Trust 2 is the boundary spanner for the Trust. She has worked in the NHS her whole career and has been at the hospital since the mid-2000s.

6.7.2 IT Case Study

The first national information technology strategy for the NHS came in 1992 (NHS Management Executive 1992). The subsequent approach in 1998 and 2002 led to creating of the National Programme for IT (NPfIT), later called Connecting for Health. It aimed to create a single electronic care record for patients, connect joint IT systems, and provide a single IT platform. This many billion-pound programme of investment dominated the digital agenda under the Labour government. The investment resulted in considerable progress being made in primary care, while secondary care lagged significantly behind. A local hospital was awarded 'global exemplar' for IT use, which resulted in the hospital being provided with central IT funding to update their clinical systems. They decided to partner with a private company to design and implement a new system which is the subject of this case study.

The NHS Trust is a major hospital in the South of the country, which serves a market town and its surrounding areas. The boundary spanner is a consultant and has worked in the NHS his whole career. He was instrumental in persuading the private company to become involved.

Founded in the 1980s, the private IT company supplies electronic health record software to the public and private sectors. Respondent 4; Snr Mgr IT is the boundary spanner for the IT company. She joined the company in the 1990s as an analyst with a background in developing systems. In her work, she uses her many years of experience within the health sector and her comprehensive understanding of how IT can improve clinical processes.

6.7.3 WOS Case Study

Wholly owned subsidiaries (WOS), in a definition provided by NHS Providers (2018), are an organisational and governance form that NHS Trusts can legally adopt to manage part of their organisation. In setting up a WOS, NHS Trusts retain 100% of the shares in the company, ensuring that all aspects of the organisation remain under their control. The legislation, introduced in 2006 by a Labour government, enabled foundation trusts to set up a WOS and attracted little controversy. However, with the increase in the number being set up by trusts in response to a change in the strategic direction in the NHS requiring them to support new models of service delivery, the profile of these subsidiaries has increased. As a result, they have attracted strong criticism from the health unions and the Labour party.

The NHS Trust is a single site Foundation Trust. The WOS aims to support the Trust's strategic objectives, improve efficiency, and develop more cost-effective ways of working. The WOS provides a full range of professional estate and facilities services and IT, procurement and financial services to the NHS Trust and other clients. Over 300 staff transferred under TUPE regulations to the WOS. Respondent 5; Snr Mgr NHS Trust is the Trust boundary spanner. He is an experienced healthcare manager with a history of working in both Acute Provider and Commissioner settings. He has worked for both the NHS and the private healthcare sector. Respondent 6; Snr Mgr WOS is the WOS boundary spanner. He is a qualified accountant and joined the NHS as a graduate trainee. He has held a variety of jobs, both in the private sector and the NHS. He joined the Acute Trust in the mid-2000s.

After two years of effort, four very different but exciting partnerships had agreed to participate in the fieldwork. Now that the type and variety of partnerships are known, it is helpful to summarise the information collected for each case study.

6.8 Summary of Data Collected by Case Study

Set out in the table 24 below is a summary of the data collected during the fieldwork.

TABLE 24: SUMMARY OF FIELDWORK DATA COLLECTED

Case study	PAT Questionnaire	Semi-structured interview	Interviewees

Pathology	3	5	Respondent 1; Mgr Pathology Respondent 2; Mgr Pathology NHS Trust 1 Respondent 3; Mgr Pathology NHS Trust 2 Respondent 11; Snr Stakeholder Pathology Respondent 12; Senior Stakeholder Pathology NHS Trust 2
IT	2	3	Respondent 4; Snr Mgr IT Respondent 9; Snr Stakeholder IT Respondent 10; Snr Stakeholder IT NHS Trust
WOS	2	4	Respondent 5; Snr Mgr WOS NHS Trust Respondent 6; Snr Mgr WOS Respondent 7; Snr Stakeholder WOS Respondent 8; Snr Stakeholder WOS NHS Trust

Own Exhibit

The ethical and practical issues involved in the data collection needed to be considered. These are reviewed in the next section

6.9 Ethical and Practical Data Collection

Previous sections have concluded that on identifying key boundary spanners within a partnership, they need to be interviewed to obtain background information about their careers to date, obtain as much contextual information about the partnership as possible and complete a PAT.

6.9.1 Ethics Approval

Before any fieldwork was allowed to take place, the University must give ethical approval to the study. This process was carried out by completing a form that required a summary of the project, an outline of the research methodology and how the researcher would handle consent, confidentiality and data storage. After some tweaks and clarifications, the University of Birmingham gave ethical approval for the study in December 2015. As highlighted in the previous sections, there were several iterations to the way the data was collected. However, it was not necessary to reapply for ethical approval from the University because it had been written to provide flexibility around how the researcher collected the information. For example, two participation information sheets were initially written: one for semi-structured

interviews and the other for completing the PAT. After the researcher decided to combine these two aspects of the fieldwork, he merged the participation letters.

6.9.2 Identifying Participants

The first task was to identify boundary spanners within the three sites. The researcher achieved this by requesting relevant names and contact details from the primary contact in each case study and then sending them an email (see Appendix 2 – Participation in PhD research). The letter explained where the researcher had obtained their contact details, a brief explanation of the purpose of the research and what part their information would play. It explained that the researcher would write up the results in a confidential report and send them a copy. It assured them of the confidentiality of the information they provided.

6.9.3 Providing Participants with Information

Once the researcher obtained an agreement from the boundary spanner to participate, they were sent an information sheet (see Appendix 3 – Participation Information Sheet – Semi-structured interview and questionnaire). The information sheet thanked the addressee for agreeing to participate in the fieldwork. It provided more in-depth detail about the research aims. It explained that they would be participating in an interview taking approximately 45 minutes and, at the end, would be completing a questionnaire. He reiterated that the information obtained would be anonymised.

6.10 Dual Perspective

Research shows that it is helpful to obtain alternative perspectives when exploring job performance and roles with individuals (Paglis and Green, 2002, Tyson and Ward, 2004). This means that as well as selecting boundary spanners to interview, senior stakeholders from the organisations in each case study were identified and interviewed to obtain an enhanced view of the roles played by the boundary spanners.

6.11 Conclusion

This chapter looked at various research designs that were potentially applicable for my fieldwork before picking the most useful, the comparative case study approach. The many issues with case study design were considered, and ways to mitigate

were thought through and implemented for the data collection. The selection of each partnership case study was described in detail as the process was fraught with difficulty and setbacks. Finally, how data collection was initially envisaged and then altered after a trial period to improve the process was described. This has allowed for a significant amount of data to be collected during the fieldwork stage of the research, the results of which are the subject of the next chapter.

CHAPTER 7 - RESULTS

The chapter aims to provide the empirical results from the documentary evidence, the questionnaires, and the semi-structured interviews that lead to the analysis and interpretation in chapter 8. Qualitative methods have been employed to test the research questions developed through extensive exploration of the topic in advance of the data collection. As outlined in chapter 1, the two research questions are as follows:

> (1) How do the characteristics of the boundary wall change depending on the organisations that make up the NHS PPP?
>
> (2) Does the strength of the boundary wall impact the roles and behaviours of boundary spanners?

To answer these questions, the thesis systematically compiles the results from the cases, starting with understanding the context of each one. The chapter is therefore structured as follows. Section 7.1 provides context to each case through documentary analysis and insights from interviewees (both boundary spanners and senior stakeholders). As pointed out by Stake (1995) and Yin (1994), documents and archival records are sources of evidence in case studies. Documents enhance understanding through the ability to situate contemporary accounts within a historical context (May, 2001). Section 7.2 provides insights into the 'Boundary Wall' (PAT scores and interviews – both with boundary spanners and with senior stakeholders). Section 7.3 investigates the role of boundary spanners (interviews), and finally, section 7.4 covers the history and evolution over time (interviews).

7.1 Case Study Documentary Research

The researcher retrieved the documents from multiple sources providing a rich tapestry of interlocking information that is very helpful in setting the context of each case and provides excellent insights for use in the discussion chapter. However, the reliability and validity of these documents are rarely perfect, so the researcher was meticulous in buttressing an analysis of the organisation documents with other supporting sources of data. In addition, comments by boundary spanners in the semi-structured interviews were included that either support or cast doubt on the integrity of the documents.

7.1.1 WOS Case Study

7.1.1.1 Documents

The thesis explores the decision-making process of the Trust in deciding to create the wholly-owned subsidiary (WOS). It has been necessary to scour the trust's annual reports, board meeting minutes, and operational plans to achieve this. It seems, in response to a question by a member of the public, contained in the minutes of the 20th December 2017 board meeting, the trust started looking at the potential to create WOS Ltd in 2016 by appointing a consultancy company to carry out a feasibility study:

> 'Consultancy Ltd was appointed to carry out some scoping work in 2016. As part of the Trust Board decision to progress the project in January 2017, the appointment of Consultancy was approved on the basis that they already had significant knowledge of the Trust gained through this scoping exercise and would be able to provide the greatest continuity, knowledge, experience, and efficiency, together with access to a large amount of legal and process documentation.' (Question 12, Annex 1 of 20th December 2017 board minutes)

Despite stating above that there was a board decision to progress the project in January 2017, the first mention of the WOS in any publicly available document was in the minutes of the 25th October 2017 board meeting. This was despite the company being incorporated at Companies House on 3rd July 2017. The executive team provided the following statement to the board meeting (Trust Board Minutes, 2017):

> 'the trust has now briefed all staff who will be transferred to WOS when the subsidiary company is set up in February 2018. Other staff in the organisation have also been briefed on the rationale and process we will be following. TRUST continues to engage proactively with union colleagues and staff and will begin the formal consultation on TUPE in November'.

At the 20th December board meeting, a paper (Trust Board Minutes, 2017) was presented to the board by the Associate Director of HR. In addition, they were asked to review feedback from staff and Trades Unions during the formal consultation period. This was before deciding whether or not to approve the establishment of a

wholly-owned Estates and Facilities Management Subsidiary Company to provide the Trust with a fully managed healthcare facility.

Approval was given at the board meeting as immediately following it, a letter (Creation of a New Subsidiary Company of Trust 2, 2017) was sent on to all trade unions confirming board approval to set up the WOS as a subsidiary company of the trust and containing much the same information as that given in the presentation to board members earlier in the day.

It is interesting to note that the Trust 2017/18 annual report (Annual Report, 2017, p. 69) states 'the governors received regular information in the lead up to the commencement of WOS Limited'. If that is the case, the minutes were not comprehensive, or the Trust actively chose not to disclose the discussions to public scrutiny. A clue to the attitude of the Trust over transparency is given in response to a question submitted by the public and reported in the 20th December board minutes (Board Minutes, 2017, Question 2, Annex 1). They state:

> 'it is important to recognise that there is no legal obligation upon the Trust to consult on this decision, which will be taken in the best interests of the affected staff, the wider workforce, the Trust, and the wider NHS system.'

As reported in the Trust annual report (Annual Report, 2018, p. 07)

> 'garnered media attention both on a regional and national basis due to the TUPE of estates and facilities staff to the subsidiary company'.

In addition, the response from the Trade Union movement was swift. For example, a UNISON regional officer stated:

> 'NHS staff sent a clear message to the Trusts board on Wednesday (20th December 2017). Over a third of the workforce – 772 staff – have signed a petition calling on the Trust to pause the WOS decision and consult properly. Suggestions from senior board members that staff didn't know what they were signing are an insult to health workers'.

She goes on to make the following points:

> ‘Let’s get the facts straight. The Trust claim they consulted for five months – wrong. Staff were not informed of the plan until October, and key documents were provided after the WOS decision had been made.
>
> 'Hundreds of staff at Trust 2 have lost out thanks to the cavalier attitudes of senior management. They have put Trust 2 in breach of licence because they were so desperate to avoid asking staff what they thought of the sub co plan. The reason for that is clear – hospital staff know that the sub co plan is a mistake and would have said so to their bosses'.

The UNISON officer requested a pause to the plan. There was no recorded response from TRUST to this request, and the WOS Ltd started trading from 1st February 2018.

It was not until the publication of the 2017/18 annual report (Annual Report, 2018, p. 50) that rationalisation for the Trust decision to set up WOS Ltd as a WOS was made public. The relevant section of the report states:

> ‘WOS has been set up to support the Trust's strategic objectives, improve efficiency and develop more cost-effective ways of working. WOS provides a full range of professional estates and facilities services along with IT, procurement and financial services to the Foundation Trust and other clients. Around 350 staff transferred under TUPE regulations to WOS Ltd on 1st February 2018.
>
> The key objectives of establishing the WOS are as follows:
>
> - Maintain and improve quality of services
> - Free up Trust management to focus on healthcare
> - Develop a more efficient and cost-effective service
> - Retain staff within the TRUST group providing opportunities and security
> - Enhance the ability to recruit and retain key staff groups
> - Enhance focus and flexibility on developing additional income generation opportunities
>
> WOS operates as an arm’s length organisation with its own board of directors and governance structure. Services are provided under contractual

arrangements with detailed service specifications and key performance indicators.'

The Trust 2018/19 annual report (Annual Report, 2019, p. 17) contains a section on the performance of WOS Ltd which is very positive. It states:

> 'The Trust's wholly-owned estates and facilities management company, WOS Ltd, commenced operations in February 2018. WOS Limited was created to ensure that the Trust is able to develop cost-effective services together with enhancing the ability to recruit and retain key staff groups. The company protects existing jobs, creates new employment opportunities in the local community and ensures the continued quality provision of crucial hospital services. The Trust considers that WOS Limited and all members of staff employed are very much a part of the Trust group and the values, culture and objectives for the company and the Trust are closely aligned.
>
> WOS Limited's overall performance during its first 14 months of operation has grown in strength with financial targets being exceeded and key service metrics showing strong performance. The organisation has grown its profitable customer base and service offering. Courier services have been established and provide a higher quality service at a lower cost to the Trust. Maintenance, compliance and other services are provided to a number of customers including the GP practices operated by Symphony Healthcare Services Limited.
>
> All necessary accreditation for the performance of high quality, effective services has been achieved and maintained along with achievement of the Cyber Essentials accreditation. WOS Limited continues to drive efficiency and utilise technology to provide enhanced cost-effective services. A new group-wide printing solution has been implemented providing greater security at reduced cost, a portering management system is being implemented and an equipment tracking solution is under consideration.

The financials certainly seem to agree with these positive comments with the Trust reporting (Annual Report, 2019, p. 52) an increased turnover from £272,000 in 2017/18 to £1.442 million in 2018/19 (p. 52).

Around the time of the formation of the WOS, the setting up of wholly-owned subsidiaries started attracting significant press and political coverage. A briefing by NHS Providers (2018) provides a helpful background. They state that Trusts have set up subsidiaries since 2010 without attracting any controversy. However, with the increase in the number being set up by Trusts in response to a change in the strategic direction in the NHS requiring them to support new models of service delivery, the profile of these subsidiaries has increased. They have provoked strong criticism from health unions and Labour. This resulted in NHS England issuing a consultation document in October 2018 and a further revision in November 2018, which effectively put more barriers in place for when NHS hospital trusts wish to set up private companies and transfer staff into them. As Saffron Cordery (2018), Deputy Chief Executive of NHS Providers, states in response to the consultation

> 'We are concerned that the level of detail and the steps outlined in the new review process go a long way beyond what is typically expected of trusts and what is required for other transactions and commercial activities. There are many reasons why a Trust may choose to establish a WOS. These go well beyond just making tax savings. The process NHS Improvement is choosing to adopt here sets the bar too high and introduces an unwelcome extra administrative burden into the sector. There is a danger that trusts will abandon innovative WOS plans and instead look to less preferable alternatives.

7.1.1.2 Interviewee Comments

As outlined in section 6.7, the researcher interviewed two boundary spanners and two senior stakeholders for the WOS case, two from the NHS Trust, and two from the private company. Comments below are taken from the transcripts and coded to illustrate the context of the partnership's proposed creation and start-up. The WOS partnership allowed the private company more commercial freedom than if it was still part of the trust.

WOS provides for many freedoms and benefits for the management of the private company as described by Respondent 6; Snr Mgr WOS:

> 'The concept really was to be able to provide a more responsive, focused, cost-efficient service back to the trust'.

> ‘We’re also selling additional business to other organisations as well, which is not something we were particularly focused on previously’

This freedom of action was confirmed by Respondent 7, Snr Stakeholder WOS:

> ‘So, there are big opportunities to pull in work from outside the NHS, which generally we wouldn't have pursued if we had been a non-commercial body’.

WOS is not treated like any other private sector company by the trust as it is staffed by colleagues that have worked at the trust for many years. As Respondent 5; Snr Mgr NHS Trust WOS describes it:

> ‘I’ve got to say it is a quite different relationship because they were, still are a part of us…we already knew the people that were going off to WOS...you weren’t having to learn about how those people were, get to know them, understand how they worked’.

> ‘I think they get a more welcome response from us than a private company would’

Respondent 8; Snr Stakeholder WOS NHS Trust did not see any changes at all when the Trust created WOS:

> ‘I could describe it as a change of letterhead. But that was all. How we interact with them, how we request their services didn't change at all for us. And the people didn't change. So, it didn't change in the slightest’

The Trust were very supportive of the setting up of the WOS, starting with the commercially minded Trust Board as confirmed by Respondent 6; Snr Mgr WOS:

> 'We have a very commercially focused, experienced board…with a number of accountants and legal background people on the board.'

The importance of the board is confirmed by Respondent 7; Snr Stakeholder WOS, who states:

> ‘The chief executive and finance director at the time of creating WOS kicked off this commercial attitude to work and additional work’.

Respondent 7, Snr Stakeholder WOS, also felt that the board had a positive effect:

> ‘The Board of Trust 2 were very keen to let people understand that we are all part of the wider Trust umbrella. We are all part of the same group. And it isn't an us and them approach’.

This positive attitude has been adopted by Respondent 5; Snr Mgr WOS NHS Trust:

> ‘I think more trusts should actually pursue a type of subsidiary company, purely because it gives them the freedom to do things, but then they are still held to account’.
>
> ‘It’s a good example of a partnership. We don’t view them as a subsidiary’.
>
> ‘And they are very keen to go out and pursue other opportunities, which is good’.

It is interesting to note how this positive attitude can change over time when board members are replaced. Respondent 7, Snr Stakeholder WOS puts it like this:

> ‘We've now got in some board members who weren't necessarily there when we set up WOS and maybe are thinking, is this really the NHS way?’

And he goes further when commenting on the situation after two board members left:

> ‘We are in a different position than we would have been if they were still here. Which from a WOS point of view is unfortunate. What you ended up with now is two NHS traditional type of people at the top who don’t really see a WOS benefit’.

Respondent 6; Snr Mgr WOS makes it clear that a Trust workforce communication strategy before and after WOS was spun off was crucial:

> 'Before we transferred the messaging and communication with the staff had to be very sort of sensitive….you'll be doing the same job in the same place with the same people for the same money’.

Even with the sound thought-through communication exercise, there was still uncertainty and worry in the workforce, resulting in higher than usual staff turnover. As Respondent 6; Snr Mgr WOS:

> 'At the start….we've had a little bit of staff turnover, on the ground floor’.

This was confirmed by Respondent 7; Snr Stakeholder WOS:

> ‘If we go back to before WOS was set up, I think that you've got quite a lot of negativity, certainly around the Unions. And some of the staff groups might not have been overly happy about not being part of the NHS’.

And Respondent 8; Snr Stakeholder WOS NHS Trust:

> ‘Definitely concerns. I wasn’t involved but I know they did a lot of work with the Unions to make sure they understood’.

7.1.2 IT Case Study

7.1.2.1 Documents

Both organisations within this partnership could not provide any documents about the overall contract they were working under, citing the commercial-in-confidence nature of the partnership relationship. However, both organisations refer to their partnership in the press release sections of their websites. For example, in a September Press Release (2016) the NHS organisation proudly talks about the hospital being named by the government as a ‘global exemplar’ for IT use. They go on to state:

> ‘For its digital programme, the Trust used openIT, the UK's first open-source electronic patient record, supplied by pioneering software company IT. This gave the Trust access to £45 million worth of software development without the need for a licence fee. The technology, created with clinicians over 30 years, also gave the trust more control than an off-the-peg solution, allowing it to tailor the system to local needs and make improvements swiftly'.

The private organisation carries the same story within the case study section of the website. They provide more detail concerning the challenges involved in the partnership and how these were overcome. Again, there is a very positive spin put on how well the team delivered the project.

The clinical project lead for the Trust wrote an article about the design and implementation of the new IT system where he complements the partner for their performance over phase one of the project saying that the clinicians rated the company highly. He also points out that clinical, nursing and wider staff engagement was crucial from involvement at the beginning of the procurement process through to

involving them in the workstreams to define work processes and patient flows and finally to support the system as it went live.

7.1.2.2 Interviewee Comments

As outlined in table 24 of section 6.7, the researcher interviewed one senior manager and one senior stakeholder of the private company, and he interviewed one senior stakeholder of the Trust. In addition, quotes from an article written by the NHS Trust boundary spanner are included in this section where relevant. One fascinating aspect of this case study is that it involves an NHS IT implementation project notorious for wasting time and money and, ultimately an unsuccessful implementation. The NHS boundary spanner well described this perceived inadequacy:

> ‘Many doctors here, like everywhere, have an instinctive distrust of IT-based on a long track record of poor IT implementation in the NHS'.

The trust board approached replacing their antiquated electronic patient system refreshingly differently and made some critical upfront choices. They decided on using open-source software rather than purchasing an off the shelf solution from a large supplier, an approach that had fallen into disrepute. Interestingly from the Trust perspective, using open source software was a positive but not crucial. As Respondent 10; Snr Stakeholder IT NHS Trust makes clear:

> 'There was a desire to look at the open-source nature of the partnership…….but it wasn't the main strategic driver for implementing the system'.

However, Respondent 9; Snr Stakeholder IT felt it made a significant difference to being selected as the partner company:

> ‘Open sourcing…it was huge……we were one of five supply organisations taken to the wire, and to be up against the best in the world…the margin of difference in decision was so small’.

The board also decided to appoint a clinical lead to ensure they obtained engagement from the clinicians right from the start of the project by involving as many as possible in the selection procedure. As the NHS boundary spanner remarked:

> 'Clinicians were involved from the very beginning of our procurement process when we invited shortlisted suppliers to demonstrate their systems at an event with an open invitation for as many clinicians to attend as possible. As a result, many came to score the systems, with their input contributing to the final choice of supplier'.

This focus on engaging the many stakeholders was confirmed by Respondent 10; Snr Stakeholder IT NHS Trust:

> ‘From a trust perspective, we had quite an extensive project team working on this and really tried to ensure that everybody was able to contribute, and decisions were made at the right level’.

The rigorous procurement process meant that both organisations entered into the partnership with a clear set of aims and objectives and emphasised working together. As Respondent 4; Snr Mgr IT commented:

> ‘What was key (with the Trust project)….there was a lot of intense focus on working together, getting engagement, looking at the current processes and looking to see where value might be added as the system was going in’.

This was backed up by Respondent 9; Snr Stakeholder IT:

> ‘And (my equivalent Snr Mgr in the Trust) and I literally committed and looked each other in the eyes and said, we will make this happen, we will get it over the line. And we really did work as a combined team’.

However, the relationship deteriorated over time and Respondent 9; Snr Stakeholder IT is clear why that happened. The first phase (which the case study focused on) he suggests was:

> ‘Very much a honeymoon period, there’s an excitement of the new partnership. And I had a great relationship with my counterpart in the NHS organisation’.

However, as the project progressed, he felt:

> 'And so by phase 3, very much the relationship had broken, IT didn't look as shiny. IT was feeling bitter; I was feeling bitter'.

7.1.3 PATHOLOGY Case Study

7.1.3.1 Documents

There is a significant number of documents from NHS England concerning the reorganisation of pathology services in England. For example, the two reports by Lord Carter (Carter, 2006, Carter, 2008) started off the change process by recommending NHS organisations consolidate multiple laboratories into a hub and spoke model and encouraged the use of private company expertise and finance by working with them in partnership. However, uptake of recommendations has been patchy, and an article by Mark Critchard (2013) in the HSJ confirmed that:

> ‘Progress remains painfully slow, particularly bearing in mind how many years have elapsed since Lord Carter’s original report in 2008’.

He suggests that there are four core obstacles for the changes to take place. The first is limited benchmark sites by which NHS organisations can learn lessons leading to extra caution or elongated timelines as each project learns its lessons. The second obstacle is the tax position of the potential partnership as HM Revenue and Customs has confused the VAT status of the outsourced services. The third obstacle is the interpretation of competition law, where consolidation of pathology services is bumping up against ensuring that competition in the sector is not eroded too far. Finally, he suggests that any significant change in the delivery of pathology services, particularly involving the private sector, requires the buy-in from the key stakeholders, including senior management, clinicians, commissioners, and the pathologists themselves.

NHS England stepped up the pressure on acute hospital trusts in England by writing to them in September 2017, stating that they would 'need to change how they work and collaborate to drive out unwarranted variation in pathology services'. In this presentation, NHS improvement proposed potential and actual networks of trusts. They highlighted which private/acute trust partnerships provided networks and which by acute trusts working together. Two further reports have been published since then to report on progress, the first in September 2018 and the second in September 2019. It is interesting to note that both these reports omit whether the partnership operating model involves the private sector or just involves the public sector. The deadline for completing the proposed 29 pathology networks is 2021. In the 2019

report, it is stated that 97% of trusts are engaged with the process, 84% have agreed to a partnership operating model, and 76% of networks say they are on track to be operational by the 2021 deadline. The specific information about this case study in these updates states that the pathology network is up and running and has 100% engagement.

The websites of the two acute trusts that are partnering with the private company both mention the relationship. However, where one Trust mentions it in passing if the pathology page is accessed, the other Trust has a whole section on their commercial partnerships. They boldly set out their objectives when involving commercial partners, and they explain the ongoing pathology partnership when clicking on the relevant case study link.

The private company website has a brief introduction to its services and a video of the opening of its pathology hub. However, there is no financial information or any other information that sheds any light on how the partnership is performing or developing. A flow chart outlining the governance arrangements of the partnership was provided by the private company boundary spanner that helped put some of the meetings described by the NHS boundary spanners into context.

7.1.3.2 Interviewee Comments

As outlined in table 24 of section 6.7, the researcher interviewed one manager and one senior stakeholder of the private company. He also interviewed two managers and one senior stakeholder of the two Trusts for this case study.

As Respondent 1; Mgr Pathology (who was in the NHS Trust while the decision was being made as to who to partner) makes clear they were looking for specific competencies from their partner organisation which mirrors what the literature says in section 3.1.1 about why a PPP may occur:

> ‘The (pathology) management team wanted investment and the trust had no space and definitely no capital and it is quite expensive and difficult to build another pathology laboratory’.

This assertion was confirmed by Respondent 11; Snr Stakeholder Pathology:

> ‘We knew we couldn’t deliver with what we actually have, because factually even our footprint wouldn’t sustain the new equipment that we needed’.

However, even though there were real incentives and goodwill on all sides for the partnership to form, as demonstrated by Respondent 2; Mgr Pathology NHS Trust 1:

> ‘(the partnership) was done for the right reasons. There are some really, really positive things about it. It does make management of the service quite challenging’.

The creation of the contract is seen as crucial by Respondent 11; Snr Stakeholder Pathology:

> ‘I think the key thing is the structure of the joint venture contract’.

However, the actual contract was difficult to create. See these examples from Respondent 1; Mgr Pathology:

> 'It is a 20 year contract. Sometimes the NHS is asking for 5 year contracts, but there is no way a business can invest this amount of money in a 5 year contract. It can't write that off in 5 years, you have a chance to write off this type of investment in 20 years. But the contract gets reviewed every 5 years and obviously there are a lot of contractual clauses in there’.

And Respondent 3; Mgr Pathology NHS Trust 2:

> ‘(in the setting up of the contract) there were lots of things that fell down the gap….I think going forward if the NHS is going to do this, there needs to be a clear cut kind of template of how to do it and what not to forget’.

> ‘The contract is rubbish. It was a very, very poor contract, even though it was written by legal teams’.

As with the WOS case study, uncertainty about how the PPP would unfold cause difficulties with the staff involved in its creation. This quote from Respondent 3; Mgr Pathology NHS Trust 2 gets to the emotive heart of the matter:

> ‘It’s very upsetting for staff to be told one day you are moving. Their choice was either do it or leave’.

Respondent 12; Snr Stakeholder Pathology NHS Trust 2 confirmed that this did have an effect:

> ‘Unfortunately, we did lose a couple of quite senior people who were very good and were very knowledgeable’.

And this uncertainty can cause rumours to circulate. Respondent 1; Mgr Pathology highlights this issue:

> 'There is a lot of scaremongering when you first start these things that within a year, we are going to force you off your contract. No that is not the case’.

What is very interesting about this case study is that it involves three organisations, so there is not only a boundary wall between the private and public organisations but also between the two public organisations. There are tensions between the two. For instance, this is a quote from Respondent 12; Snr Stakeholder Pathology NHS Trust 2:

> ‘We like to do things one way and I know Trust 1 like to do things their way, which has made it a bit difficult with some of the lab staff who rotate between sites’.

The following is a quote from Respondent 2; Mgr Pathology NHS Trust 1:

> 'The pathology departments ….there's always been challenges between the two trusts. They always think they are better than us; we always think we are better than them'.

Chapter 8.3.2 discusses the implications of three organisations forming a PPP.

This section has used documentary evidence and quotes from the boundary spanner to understand the context of each case. In addition, the following section uses the multiple data sources provided by the case studies to assemble information about the boundary wall and its properties.

7.2 Properties of the Boundary Wall

7.2.1 Individual Properties of the Boundary Wall from PAT and Semi-Structured Interview Analysis

Each boundary spanner completed a scoring sheet for each of the six principles by either agreeing or disagreeing with six statements per principle. The boundary spanner assigned a score to each comment, and the researcher totalled them for each principle. Thus, the boundary spanner could score between 6 and 24 for each principle. Hardy et al. (2003, p.41) provide a meaning for the respondents' score for each principle. As discussed in chapter 6, the researcher adopted the PAT analysis by combining the scores from two sections that measured the same property of the boundary wall. This process was carried out for all six principles, resulting in sections that equate to the boundary wall's three properties. The researcher combined the principles described in chapter 6.3.2.2 and are repeated here for ease of understanding.

TABLE 25: SIX SECTIONS OF PAT ALLOCATED TO THE BOUNDARY WALL PROPERTIES:

Principle of PAT	Boundary wall property
1. Recognise and accept the need for partnership	Thickness
2. Develop clarity and realism of purpose	Height
3. Ensure commitment and ownership	Thickness
4. Develop and maintain trust	Denseness
5. Create clear and robust partnership arrangements	Denseness
6. Monitor, measure and learn	Height

7.2.1.1 PATHOLOGY Case Study

Trust 1 Boundary Wall

Contrasting the scores from Respondent 2; Mgr Pathology NHS Trust 1, and Respondent 1; Mgr Pathology gives an overview of the individual dimension scores for the properties of the boundary wall.

Section/wall property	Dimension	Respondent 2; Mgr NHS Trust 1	Respondent 2; Mgr NHS Trust 1 Total	Respondent 1; Mgr Pathology	Respondent 1; Mgr Pathology Total	Boundary wall score
2 - Height	Strategy	16	**30**	19	**39**	**9**
6 – Height	Strategy	14		20		
1 – Thickness	Culture	15	**31**	20	**39**	**8**
3 – Thickness	Culture	16		19		
4 – Denseness	Power	14.	**28**	19	**38**	**10**
5 – Denseness	Power	14		19		

Semi-structured interview quotes which have been coded positive (green) or negative (red) provide additional granularity to the scoring above.

Respondent 2; Mgr Pathology NHS Trust 1		
How high is the BW? Strategy/communication quotes	**How thick is the BW? Culture quotes**	**How hard is the BW? Power quotes**
As a proportion of my time it probably takes the largest amount, but as a proportion of my portfolio, its supposedly relatively small	We have very strong personalities…so sometimes challenging some of those personalities is difficult	In terms of shareholding, we are the majority shareholders
I'm not allowed to see the governance reports. There are certain things that are deemed to be commercially sensitive. You do often feel like you're trying to make a decision with one arm tied around your back	He has an absolute conflict of interest in his role and its very difficult. He's employed by our Directorate as a consultant. But he's also the Medical Director of the private company.	We pay for a lot of things that I'm not sure we should be paying for.
I meet with the private company boundary spanner on a very regular basis. I do spend a lot of time catching up	I think it was professionally embarrassing to be asked not to attend a meeting	The NHS doesn't have the commercial and legal team behind it that a massive

with people on a regular basis and trying to maintain those good relationships		company like private partner does
If I could change anything, I would be more integrated in the model.		We as a directorate are investing in some time from our procurement team to help give me some dedicated resource to unpick (the contract)
In terms of how we learn from mistakes, how we share best practice, how we take things forward, doesn't feel very joined up.		And I think where you've got a highly paid skilled business and financial team literally sitting opposite you that can be quite difficult

From the high scores for each property of the boundary wall and the preponderance of negative (red) sentiment in the comments, it is clear that Respondent 2; Mgr NHS Trust 1 is finding it difficult to boundary span this aspect of the partnership.

Trust 2 Boundary Wall

Contrasting the scores from Respondent 3; Mgr Pathology NHS Trust 2 and Respondent 1; Mgr Pathology:

Section/wall property	Dimension	Respondent 3; Mgr NHS Trust 2	Respondent 3; Mgr NHS Trust 2 Total	Respondent 1; Mgr Pathology	Respondent 1; Mgr Pathology Total	Boundary wall score
2 - Height	Strategy	17	**31**	19	**39**	**8**
6 – Height	Strategy	14		20		
1 – Thickness	Culture	16	**35**	20	**39**	**4**
3 – Thickness	Culture	19		19		
4 – Denseness	Power	13.	**27**	19	**38**	**11**
5 – Denseness	Power	14		19		

Semi-structured interview quotes which have been coded positive (green) or negative (red) provide additional granularity to the scoring above.

Respondent 3; Mgr Pathology NHS Trust 2		
How high is the BW? Strategy/communication quotes	**How thick is the BW? Culture quotes**	**How dense is the BW? Power quotes**
She literally just handed over to me after I accompanied her to one operational board meeting	It's very upsetting for staff to be told one day you are moving	The contract is rubbish. It was a very poor contract, even though it was written by legal teams. It was written by people without pathology knowledge
It has been a steep learning curve	The CEO left two years ago, and we definitely have had a more strained relationship since then, as he was the one to set it up	They don't understand how finances in the NHS work
I didn't know the BS of Private company until probably a year ago now I see him all the time.	There is a pathology committee where the pathologists should all go. None of my pathologists will attend	Some things go wrong, and its never their fault
I am quite a strong woman, but I have never been snowploughed quite so much in my life – absolutely flattened	The knowledge has walked out of the building	I think the financial situation has not helped. It doesn't promote working with a private partner because they have to work for the biggest profits that they can, and we have to say we don't make a profit out of this, we haven't got anything to give you. It has made it difficult
I didn't get the minutes from the meeting and neither did my counterpart		I can't get them to do a benchmarking exercise to see what their prices are like
I'm glad they say that its supposed to save us money. I'm not sure		We get a small profit share now but it's nothing compared to what was anticipated
Quite clear why get a private company into the NHS, absolute prime example as why would you have one lab in Y and one lab in T doing the		

same thing when you can put one in the middle all centralised, faster, automated with one group of staff instead of duplicating them		

The majority of comments are negative, which backs up the high boundary wall scores on each dimension. One anomaly was the relatively low contrasting score for the culture dimension (meaning the wall is thin) compared to all the negative comments that the boundary spanner expressed in the interview (which would indicate a thick wall). This is why it is helpful to have both types of information to draw on for the analysis.

Respondent 1; Mgr Pathology		
How high is the BW? Strategy/communication quotes	**How thick is the BW? Culture quotes**	**How dense is the BW? Power quotes**
(Before the partnership) we already had a central management team and we wanted investment	We have a very good relationship with our Trusts, and they understand and believe what we say and I think to some extent my view has always been it is the people involved that they have confidence in, so people like me on the financial side, although I am not a financial person I got very involved with the contractual side such as billing and finances.	So, the Trusts are both stakeholders and customers and often they struggle to understand themselves as a stakeholder they always think they are a customer and that is quite interesting
The structure has become quite complicated…but it is working well	I was NHS but I think they had belief that what I was saying was true and I could present and show that I was not pulling the wool over their eyes	It is a profit share process between us and heavily towards the NHS so to me it is a good model.
	We did have some unhappy staff no question we had some who believed the NHS was the	It is a 20 year contract. Sometimes the NHS is asking for 5 year contracts; there is no way a business can invest this

	only thing I don't want to work for a private company	amount of money in a 5 year contract.

The results show that the NHS boundary spanners generally agree when it comes to the strategy and power dimensions of the partnership (both record high scores for these dimensions meaning difficult boundary spanning) but there is some divergence when it comes to the culture dimension with Respondent 3; Mgr Pathology NHS Trust 2 considerably more positive about the partnership than Respondent 2; Mgr Pathology NHS Trust 1. This isn't born out when considering the comments, which are all negative It is interesting to note that the Respondent 2; Mgr Pathology NHS Trust 1 was the only one to disagree with the statement that the partnership was achieving its aims and objectives, which is born out from this analysis . The NHS boundary spanners score lower across all three dimensions compared to Respondent 1; Mgr Pathology who as can be seen from his high PAT scores and almost universally positive comments believes that the partnership is effective and boundary spanning is relatively easy.

7.2.1.2 IT Case Study

IT Boundary Wall

Contrasting the scores from NHS boundary spanner and Respondent 4; Snr Mgr IT; Snr Mgr IT

Section/wall property	Dimension	NHS Boundary Spanner	NHS Boundary Spanner Total	Respondent 4; Snr Mgr IT	Respondent 4; Snr Mgr IT Total	Boundary wall
2 - Height	Strategy	20	**43**	23	**42**	**1**
6 – Height	Strategy	23		19		
1 – Thickness	Culture	20	**41**	22	**44**	**3**
3 – Thickness	Culture	21		12		
4 – Denseness	Power	20	**44**	19	**41**	**3**
5 – Denseness	Power	24		22		

The scores on all dimensions are high by both the NHS and private company boundary spanners meaning that the boundary wall is low making boundary spanning for these individuals easy.

Semi-structured interview quotes which have been coded positive (green) or negative (red) provide additional granularity to the scoring above.

Respondent 4; Snr Mgr IT		
How high is the BW? Strategy/communication quotes	**How thick is the BW? Culture quotes**	**How dense is the BW? Power quotes**
I think what was key is that we worked very closely, so it's a very close partnership	(This partnership) is very much a joint development where we work very closely together	I think what we learned is having those objectives and time scales at the beginning and the end and really managing it as a very tight contract.
It really is doing an awful lot of upfront planning and making sure you've got the correct stakeholders	And again, its personalities and who's involved, because the team is only as good as the people you actually have	We've got a contract, but it is also about delivering.
You had a small group of people really making decisions quickly	I think having a team that has a lot of experience is very helpful	
Working very collaboratively is key. If you can get everybody operating at the top working together you can get things moving.	You need to get in there and understand what's happening.	
We have project board meetings once a month.	I think that the openness here is excellent	
	I think it is a trusted partnership	

NHS Boundary Spanner IT		
How high is the BW? Strategy/communication quotes	**How thick is the BW? Culture quotes**	**How dense is the BW? Power quotes**
It is fair to say that, to date, IT has been a success that is	Clinicians have driven the development of the software	It was affordable through a new kind of contract for the

largely due to good clinical, nursing and wider staff engagement	now in use at our hospital. They understand what has been done, and why, and are buying into it	NHS base on developing and maintaining the electronic patient record (EPR), rather than paying for a software licence; designing and implementing the EPR would be a collaborative venture
We started this partnership by involving clinicians in the workstreams to define work processes and patient flows	Many doctors have an instinctive distrust of IT base on a long track record of poor IT implementation in the NHS	
I made regular presentations to senior clinicians and at departmental meetings, so everyone was kept fully abreast of what we were doing – and why. With this understanding came a high level of adoption of the new system		

This case study stood out because the scores from both NHS and private company boundary spanners were very similar and high scoring for all three dimensions. In addition, most comments are overwhelmingly positive, which backs up the low (and hence relatively easy boundary spanning) scores for the three properties of the boundary wall.

7.2.1.3 WOS Case Study

WOS Boundary Wall

Contrasting the scores from Respondent 5; Snr Mgr NHS Trust WOS; and Respondent 6; Snr Mgr WOS

Section/wall property	Dimension	Respondent 5; Snr Mgr NHS Trust WOS	Respondent 5; Snr Mgr NHS Trust WOS Total	Respondent 6; Snr Mgr WOS	Respondent 6; Snr Mgr WOS Total	Boundary wall
2 - Height	Strategy	21	**43**	21	**38**	**5**
6 – Height	Strategy	22		17		

1 – Thickness	Culture	22	**44**	21	**39**	**5**
3 – Thickness	Culture	22		18		
4 – Denseness	Power	23	**46**	20	**42**	**4**
5 – Denseness	Power	23		22		

High positive scores for all three dimensions from the Respondent 6; Snr Mgr WOS, but even higher scores from Respondent 5; Snr Mgr WOS NHS Trust, means that there is still a boundary wall to overcome.

Semi-structured interview quotes which have been coded positive (green) or negative (red) provide additional granularity to the scoring above.

Respondent 6; Snr Mgr WOS		
How high is the BW? Strategy/communication quotes	**How thick is the BW? Culture quotes**	**How dense is the BW? Power quotes**
You will be doing the same job, in the same place with the same people for the same money	I think from the start we really wanted them to make sure that they were still feeling part of the trust	There is a strong ownership of performance and output by the company, we are managing those risks
(The staff) have started getting newsletters	What we've tried to do then is instil that bit of WOS identity as well...different logo on jackets	We've got to make a profit
The trust has an experienced and strongly commercial board with a number of accountants and legal background people	We've had a little bit of staff turnover…on the sort of ground floor	We have started bidding for other works (outside of the NHS contract)
The project advisers and the external auditors both said separately that of all the projects they've known, this was the best managed and implemented project	(we don't now)….feel constrained by thinking the NHS has to do it in a particular way	We have our own objectives in terms of performance and money and so on. But actually, as a partnership, we are aligned to drive in these benefits for the goof of the Trust

There are a lot of good reasons for the WOS, both financial and non-financial		
I've been invited now to join the Trust directors weekly meeting		

Respondent 5; Snr Mgr WOS NHS Trust		
How low is the BD wall? Strategy/communication quotes	**How thin is the BD wall? Culture quotes**	**How porous is the BD wall? Power quotes**
We have monthly meetings where we go through what the KPIs are and how well they are doing against those KPIs. If there are any issues, they normally come to me first to be resolved and goes back down to them.	We are quite entrepreneurial….(the chief executive) has a very business mind about him.	I am not saying that WOS is not commercial, but it's still part of the Trust, that's how we look at it. I think it is a bit different.
	I've got to say it is a quite different relationship because they were part of, still are part of us	It's a partnership. I can't describe it any better than being a proper partnership
	And the people that have moved to WOS are proud to work at WOS	WOS is held to slightly higher standards than our business units might be
	(The management of WOS) have been here for years. They've got a level of respect and in terms of who they are	

Almost universally positive comments by both respondents confirm the PAT scoring, showing that the PPP works very well. However, in one respect, this case study is different from the others in that the NHS boundary spanner is as or more optimistic about the three dimensions than the private sector boundary spanner.

This section has produced the results from the three dimensions of the boundary wall. In addition, it has shown some differences between each case study that would

not have been evident if the analysis had not used the scoring system devised by the researcher. The following section looks at the overall strength of the boundary wall by combining the results from the complete PAT questionnaire.

7.2.2 Overall Strength of the Boundary Wall

Once each boundary spanner completed a scoring sheet for each of the six principles, the researcher followed the comprehensive instructions by Hardy et al. (2003, p. 41) as to how to produce the analysis:

> 'The individual scores for each principle should be totalled to give an aggregate score (within the range 144 - 36) for each partner'.

Aggregate scores

- 109–144 The partnership is working well enough in all or most respects to make the need for further detailed work unnecessary
- 73–108 The partnership is working well enough overall, but some aspects may need further exploration and attention
- 37–72 The partnership may be working well in some respects, but these are outweighed by areas of concern
- sufficient to require remedial action
- 36 The partnership is working badly enough in all respects for further detailed remedial work to be essential

This provides data that, when manipulated, indicates how substantial the boundary wall is between partnership organisations.

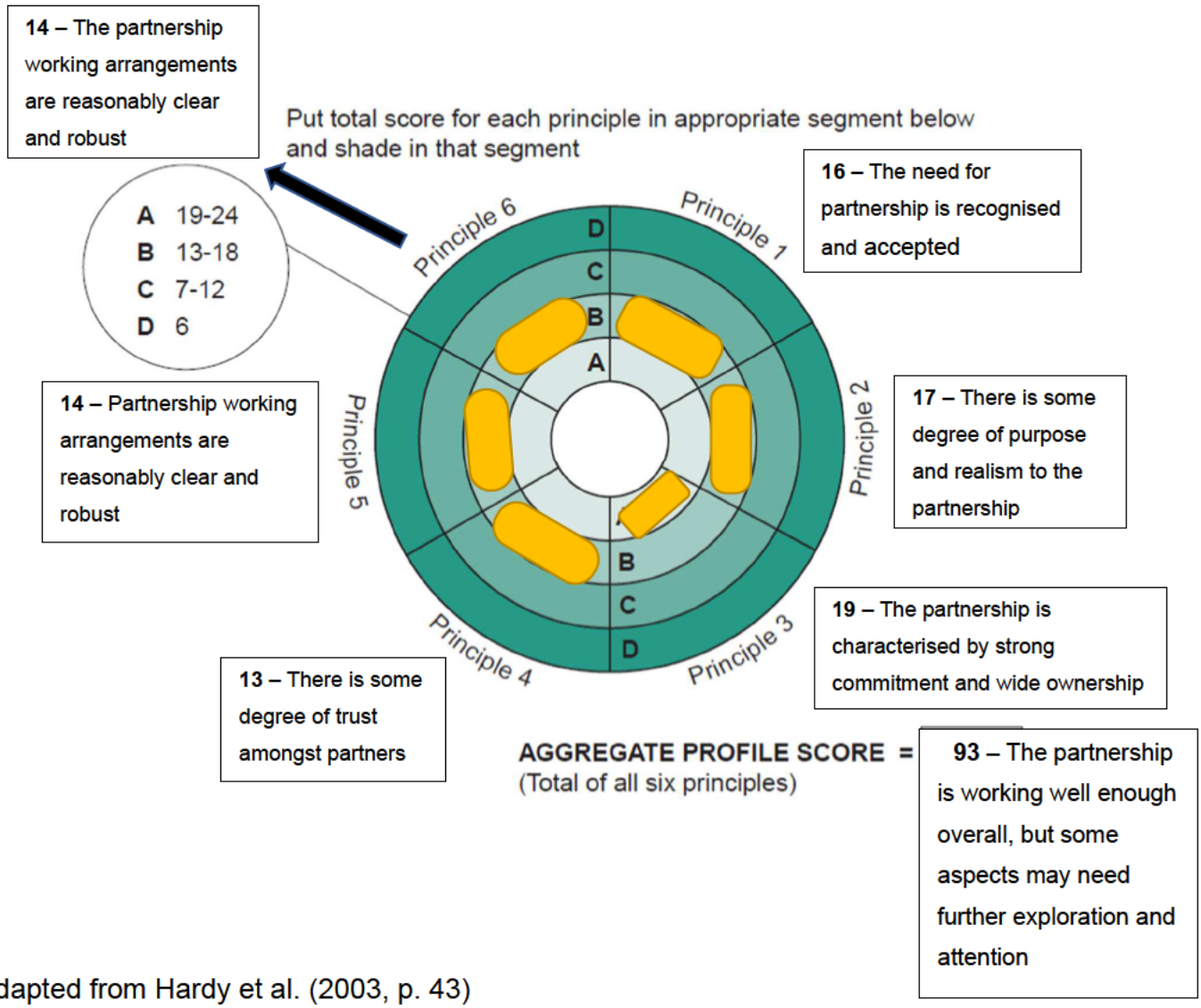
Case study	NHS boundary spanner score	Private boundary spanner score	Boundary wall
PATHOLOGY Trust 1	89	116	27
PATHOLOGY Trust 2	93	116	23
IT	128	127	1
WOS	133	117	16

An example is set out to demonstrate how numbers generated by the PAT are manipulated to derive the overall strength of the boundary wall. In the PATHOLOGY case study, there are three organisations involved, two NHS Trusts and a private

company. Hence there are two boundary walls. The difference between the two scores calculates the boundary wall. Take the PATHOLOGY case study as an example: 116 (Respondent 1; Mgr Pathology) – 89 (Respondent 2; Mgr NHS Trust 1) = 27 (boundary wall). There is an assumption that it is irrelevant whether the NHS or private boundary spanner has the higher score; it is the divergence that matters. The greater the degree of divergence in overall scores, the more substantial the boundary wall. These results mean that it is possible to calculate a number for the boundary wall. This has been done by averaging results of the NHS boundary spanners when there is more than one and then taking this away from the score of the private company boundary spanner. The results vary from 1 to 25. The PATHOLOGY case study has the most robust boundary wall, while the WOS and IT have smaller or non-existent boundary walls.

An additional way of looking at the total scores is to use the scoring method suggested by Hardy et al. (2003, p.43). The scores should be transferred to a ‘dartboard’ graphic by shading the appropriate segment for each of the six principles, an example of which is shown below for Respondent 3; Mgr NHS Trust 2. The total score for each principle is put alongside each segment, and appropriate shading is completed to allow a pattern to emerge.

FIGURE 5: RAPID PARTNERSHIP PROFILE SCORES FOR RESPONDENT 3; MGR NHS TRUST 2



Adapted from Hardy et al. (2003, p. 43)

The example above is the analysis from a completed PAT from Respondent 3; Mgr NHS Trust 2. The greater the degree of divergence in overall scores, the more extensive the boundary wall. This analysis was carried out for all the boundary spanners that completed the PAT (see Appendix 4). This pictorial presentation is a helpful summary as the tightness of the yellow circle represents how effective the respondent views the partnership. The tighter the circle means, the more cohesive the partnership.

7.2.2.1 Is the Partnership Achieving its Aims and Objectives?

In addition to the above general analysis, at the end of the PAT, each boundary spanner was asked:

> ‘To what extent do you agree with the following statement - The partnership is achieving its aims and objectives - regarding the Partnership, as a whole, which is the subject of this assessment?’

They could strongly agree, agree, disagree, or strongly disagree. The results of asking the boundary spanners whether the partnerships are achieving their aims and objectives are displayed below:

Case study	NHS Trust	Private
PATHOLOGY - Trust 1	Disagree	Strongly agree
PATHOLOGY - Trust 2	Agree	Strongly agree
IT	Agree	Strongly agree
WOS	Strongly agree	Strongly agree

The PAT scores, boundary wall and overall partnership effectiveness all tie in very well. The results are overwhelmingly positive, with 50% of the respondents saying they strongly agree, 40% agreeing, and only 10% disagreeing with the statement that the partnership was achieving its aims and objectives. This translates into the boundary spanners of three out of the four case studies agreeing that the partnerships are working well. In the PATHOLOGY case, one NHS Trust and the private sector company believe the partnership meets its main aims and objectives. The other NHS Trust does not accept the partnership is meeting its aims and objectives. This result is not surprising as it has the highest boundary wall out of all the case studies. In the WOS case study, the boundary spanners are effusive about the partnership's success, with both strongly agreeing with the statement.

7.2.3 Fourth Property of Boundary Wall

As discussed in chapter 6.3.4.3, the researcher needed additional codes to entirely understand what the boundary spanner was saying. These new codes coalesce around the focused code of ‘environment’. The impact of financial pressure looms large with Respondent 2; Mgr Pathology NHS Trust 1 talking about not receiving additional income from the partnership ‘I think it’s probably put an increased pressure on the model because there hasn’t been the amount of external income, we were expecting’. Respondent 3; Mgr pathology NHS Trust 2 refers to the additional pressures on the partnership due to budget constraints: ‘I mean if we were flush with money, I think probably private enterprise with the NHS would work much better’.

Conversely, the release of a central budget can be a catalyst. Respondent 4; Snr Mgr IT comments, 'sometimes it is timing as well in terms of the funding and the NHS digital academy coming at the right time'. Then there is the pressure that partnering with the NHS creates. Respondent 3; Mgr Pathology NHS Trust 2 explains that: ‘In our neighbouring Trust, people were marching through the streets at the thought of losing pathology to an outsourced company’ and Respondent 1; Mgr Pathology comments ‘NHS people don’t like change, you have a lot of consultants involved with pathology who say over my dead body is this Trust going to let my pathology go’ and Respondent 5; Snr Mgr WOS NHS Trust states ‘The health service is so unionised, that it doesn’t matter what you are trying to do. In the health service it’s really difficult to get rid of somebody. We end up keeping a lot of people that maybe we shouldn’t keep’. A change in government policy can have a significant impact as Respondent 6; Snr Mgr WOS shows: ‘A number of trusts were getting nervous (about creating a WOS). We know North Bristol stopped theirs. We know Bath has put a halt to theirs. I think it’s a real shame actually’.

Changes to the Department of Health policy can have a significant impact. Respondent 9; Snr Stakeholder IT states, ‘and there was an element on both sides of being a bit scared because the new dynamic was the NHS GDE program and their oversight, and they were the new masters’. Other parts of government besides the Department of Health can have an impact. HMRC are seen by Respondent 7; Snr Stakeholder WOS to cause problems. He states that the HMRC requirement to 'be seen as an arm's length body for tax purposes means that barriers are erected to thwart joined-up working.

7.3 The Roles and Activities of the Boundary Spanners

As described in chapter 6.3.4.5, the coding methodology was used to highlight all the different roles and competencies displayed by the boundary spanner when answering questions from the semi-structured interview. The results show a page by page analysis of each transcript with the number representing the number of times the role was displayed on each page. The total shows the aggregate number of times the boundary spanner uses each role during the day to day discharge of her boundary spanning duties. The results are demonstrated case initially by case, and

then a summary table of all boundary spanners is displayed, combining their dominant roles with the size of the boundary wall.

7.3.1 PATHOLOGY Case Study

Respondent 3; Mgr NHS Trust 2	Page 1	Page 2	Page 3	Page 4	Page 5	Page 6	Page 7	Page 8	Page 9	Page 10	Total
Reticulist		1	1								**2**
Interpreter / communicator	1	1	2		2	2			1		**8**
Coordinator		1	1	2		1		2			**7**
Entrepreneur											**0**

Respondent 3; Mgr Pathology NHS Trust 2 has a clear preference for Interpreter/communicator and Coordinator role elements.

This can be seen in the quote from Respondent 12; Snr Stakeholder Pathology NHS Trust 2:

> ‘We have a monthly management meeting. And during that we discuss everything. We'll go through like a normal structure of that incident reporting, turnaround times issues, development staffing, things will cover the whole box in that monthly thing. And that gets back to the private company and trusts as well’.

Respondent 2; Mgr NHS Trust 1	Page 1	Page 2	Page 3	Page 4	Page 5	Page 6	Page 7	Page 8	Page 9	Page 10	Total
Reticulist						1	1		1		**3**
Interpreter / communicator				4	1	1	1	3			**10**
Coordinator			1		1		3		1	1	**7**
Entrepreneur											**0**

Respondent 2; Mgr Pathology NHS Trust 1 has a clear preference for Interpreter/communicator and Coordinator role elements.

Respondent 1; Mgr Pathology	Page 1	Page 2	Page 3	Page 4	Page 5	Page 6	Page 7	Page 8	Page 9	Page 10	Total

Reticulist									1		**1**
Interpreter / communicator									2		**2**
Coordinator										1	**1**
Entrepreneur			2		2	2		1		1	**8**

Respondent 1; Mgr Pathology has a clear preference for the entrepreneur role element. This inclination may in large part be due to the role he is now performing but as Respondent 11; Snr Stakeholder Pathology points out:

> ‘I think Mgr; Pathology and I within the pathology department, we were always quite entrepreneurial, and business-like, we did run it with our clinical director, almost as a business’.

The Mgr; Pathology is recognised as being critical to the JV for producing the required data and documentation. Here is Respondent 12; Senior Stakeholder Pathology NHS Trust 2:

> ‘And Mgr; Pathology is very good at reminding us to ensure the document management systems are all up to date, or something needs renewing, things like that’.

And here is Respondent 11, Snr Mgr Pathology:

> ‘Mgr, Pathology did a brilliant job, collecting the data, as he always does, he does all the cross diagnostic data which has nothing really to do with us’.

There is a significant contrast between the NHS boundary spanners who display no entrepreneurship and the private company boundary spanner, where it is the most popular role element. However, the roles played by the NHS boundary spanners are very similar to each other. The senior managers from the JV confirmed this when they talked about how both boundary spanners worked in similar ways and were very supportive of each other. For instance, this is what Respondent 11; Snr Mgr Pathology says:

> ‘Developing relationships is key to communicating and supporting with transparency, of which Mgr NHS Trust 2 and Mgr NHS Trust 1 and my good self always did’.

7.3.2 WOS Case Study

Respondent 5; Snr Mgr NHS Trust WOS	Page 1	Page 2	Page 3	Page 4	Page 5	Page 6	Page 7	Page 8	Page 9	Page 10	Total
Reticulist								1			**1**
Interpreter / communicator							1			2	**3**
Coordinator							1		1	1	**3**
Entrepreneur											**0**

Respondent 5; Snr Mgr WOS NHS Trust has a clear preference for Interpreter/communicator and Coordinator roles. For instance, Respondent 7; Snr Stakeholder WOS states:

> ‘Whereas Snr Mgr WOS NHS Trust isn't really bothered about the minutiae all he is interested in is he getting the service that he pays for. And anything outside of that service, is it necessary? Yes, it is. And that's fine’.

And

> ‘Snr Mgr WOS NHS Trust has a good pragmatic approach to most things. He is quite a sensible fellow’.

Respondent 6; Snr Mgr WOS	Page 1	Page 2	Page 3	Page 4	Page 5	Page 6	Page 7	Page 8	Page 9	Page 10	Page 11
Reticulist							2	2			
Interpreter / communicator			2					3			
Coordinator		1	1								1
Entrepreneur		1		1					1	2	1
Respondent 6; Snr Mgr WOS	Page 12	Page 13	Page 14	Page 15	Page 16						**Total**
Reticulist											**4**
Interpreter / communicator		1	2								**8**
Coordinator			1								**4**
Entrepreneur				1							**7**

Respondent 6; Snr Mgr WOS prefers Interpreter/communicator and Entrepreneur roles elements where he is very effective. For instance, Respondent 8; Snr Stakeholder WOS NHS Trust says:

> ‘And Snr Mgr WOS is probably the nicest man in the world. So, he would have done it extremely diplomatically’ and ‘he's always had an incredible level of professionalism. He's always been incredibly responsive’.

Respondent 7; Snr Stakeholder WOS confirms ‘Snr Mgr WOS and the board have got a good relationship’.

7.3.3 IT Case Study

Respondent 4; Snr Mgr IT	Page 1	Page 2	Page 3	Page 4	Page 5	Page 6	Page 7	Page 8	Page 9	Page 10	Page 11
Reticulist		2				1		1			
Interpreter / communicator				1	1	1	1				
Coordinator			2	1		1	1		1		
Entrepreneur	1			1							
Respondent 4; Snr Mgr IT	Page 12	Page 13	Page 14	Page 15	Page 16						**Total**
Reticulist											**4**
Interpreter / communicator		1									**5**
Coordinator											**6**
Entrepreneur			1								**2**

The roles played by Respondent 4; Snr Mgr IT are spread pretty evenly between all four elements, but with a slight preference for the coordinator role. The fact that the Interpreter/communicator role was not as dominant as for other boundary spanners might have a bearing on both Snr Stakeholders of the JV feeling that the Snr Mgr IT needed to improve these skills. Respondent 9; Snr Stakeholder IT showed his frustration:

> ‘But I felt let down that, for whatever reason, Snr Mgr IT wasn't able to absorb and listen to the challenges that needed to be addressed’.

Respondent 10; Snr Stakeholder IT NHS Trust also voiced his frustration:

‘We could have workshops with members of Snr Mgr IT’s team. But if Snr Mgr IT wasn't available, we couldn't get decisions made, or we'd have to repeat it all with her’.

To shed light on this question, the researcher combined the results of all the boundary spanners roles into the table below.

	Respondent 3; Mgr Pathology NHS Trust 2	Respondent 2; Mgr Pathology NHS Trust 1	Respondent 1; Mgr Pathology	Respondent 5; Snr Mgr WOS NHS Trust	Respondent 6; Snr Mgr WOS	Respondent 4; Snr Mgr IT
Reticulist	2	3	1	1	4	4
Interpreter/Communicator	8	10	2	3	8	5
Coordinator	7	7	1	3	4	6
Entrepreneur	0	0	8	0	7	2

The results below summarise the data for all boundary spanners combining their dominant role elements with the size of the boundary wall calculated in section 7.2.2.

Boundary spanner	NHS/Private	Main types of boundary spanning role	Boundary wall
Respondent 2; Mgr NHS Trust 1	NHS	Interpreter/communicator and Coordinator	27
Respondent 3; Mgr NHS Trust 2	NHS	Interpreter/communicator and Coordinator	23
Respondent 1; Mgr Pathology	Private	Entrepreneur	25
Respondent 5; Snr Mgr NHS Trust WOS	NHS	Interpreter/communicator and Coordinator	16

Respondent 6; Snr Mgr WOS	Private	Interpreter/communicator and Entrepreneur	16
Respondent 4; Snr Mgr IT	Private	Interpreter/communicator, Coordinator and Reticulist roles	1

It is interesting to note that all three NHS boundary spanners display no entrepreneurial role elements. In contrast, two out of three private company boundary spanners exhibit strong entrepreneurial roles, with the third one presenting occasional entrepreneurial role elements. This result might well reflect the type of organisations that the boundary spanners reside. This is also reflected by all three NHS boundary spanners displaying a similar combination of role elements, with Communicator/Interpreter and Coordinator being the dominant combination. It is impossible to say why there is a similarity of roles, but the researcher will discuss it further in chapter 8. Disappointingly it isn't easy to discern a pattern between boundary panning roles and the size of the boundary wall. The researcher will explore the reasons for this in chapter 8, but future methodology will need to be fine-tuned to obtain more precise data. Overall, the Interpreter/communicator role was the most popular role element used by the boundary spanners, which is not surprising as transferring information between organisations in a partnership is key. However, where the role is not dominant, as in the IT boundary spanner, it can be seen as an issue.

7.4 Work History, Training and Length of Time as Boundary Spanner in Case Studies

In chapter 4, Williams (2012) argued that the roles and activities expected of boundary spanners place considerable pressure on their abilities. These are not easy jobs as they aim to persuade people to carry out requests that they may not be inclined to follow without the hierarchical power to insist. This puts a significant onus on the competencies and personal attributes that boundary spanners bring to the job. These may be skills (technical and interpersonal), knowledge of particular areas of expertise, or accumulated knowledge from carrying out the role. In addition, although not competencies, the personality and work history of the boundary spanner can influence how the roles are performed. In addition, chapter 6 highlighted

the potential reduction in the internal validity of the case studies by boundary spanners having very different work histories and experiences. To test whether the case studies shed light on these claims, an analysis was carried out on the work history of each boundary spanner and pertinent quotes recorded. The results are shown below.

7.4.1 Boundary Spanner Work History

The table below sets out the work history of the boundary spanners.

TABLE 26: WORK HISTORY OF BOUNDARY SPANNERS

Name	NHS experience	Private company experience	Length of time as BS in partnership	Partnership age
Respondent 6; Snr Mgr WOS	Yes	Yes	Since inception	2018
Respondent 5; Snr Mgr NHS Trust WOS	Yes	Yes	Since inception	2018
Respondent 2; Mgr NHS Trust 1	Yes	No	2 years	2012
Respondent 3; Mgr NHS Trust 2	Yes	No	5 years	2012
Respondent 1; Mgr Pathology	Yes	No	Since inception	2012
Respondent 4; Snr Mgr IT	No	Yes	Since inception	2014

The selection of boundary spanners was not particularly rigorous or competitive, as confirmed by the following comments from Respondent 5; Snr Mgr WOS NHS Trust: ‘I had an interview with a number of directors, and they said, you are good, so there you go’. Respondent 6; Snr Mgr WOS: ‘I came in again on a consultancy basis for a couple of months, and then ended up doing it full time. It just sort of happened. My type of skills matched’.

Background skills of the boundary spanner was seen as important either with having them or lacking them. For instance, Respondent 5; Snr Mgr WOS NHS Trust: ‘I think it really helped me that I have a strong finance background’ and ‘I’ve spent a lot more of my time doing non finance stuff, understanding the link between finance and (the rest of the business)’. Respondent 6; Snr Mgr WOS commented: ‘And then

coming back into the NHS, I've got that wealth of experience that other people don't have. I can actually see it from the private providers side of things. Respondent 1; Mgr Pathology: 'The reason I got so involved was I produced all the data, volumes of data. So people like me on the financial side, although I am not a financial person, I got very involved with the contractual side such as billing and finances'. Respondent 2; Mgr Pathology NHS Trust 1: I don't have a pathology background, which is also quite challenging. One of the huge challenges for me to start with was just find out where we were.

7.4.3 Boundary Spanner Role Induction

There was very little formal induction process for any boundary spanners, which made the role for one in particular difficult at the start. These are the coded comments from Respondent 3; Mgr Pathology NHS Trust 2: 'There's never been any dedicated training for particularly Pathology or working with a partnership organisation in Pathology. And I could have done with some. And 'but she literally just handed over to me. I accompanied her to one operational board meeting'.

7.4.4 Continuing Professional Development

On the job learning is available, but it is generated by the individual boundary spanners themselves rather than a well-thought-out development plan. For instance, Respondent 2; Mgr Pathology NHS Trust 1 comments: 'But I think in terms of my relationships and my input, I probably feel a bit more competent about the model than I did a year or so ago. Respondent 3; Mgr Pathology NHS Trust 2 states: 'It has been a learning curve, a steep learning curve' and Respondent 4; Snr Mgr IT expands on how reviewing your own performance is important: 'And I think what we have between both parties, there's an awful lot of experience there with the willingness then to constantly review and learn from that. If we need to have straight conversations, then we have straight conversations'.

7.5 Conclusion

To answer the two Research Questions, qualitative data were systematically compiled from the cases, starting with understanding the context of each one. The researcher achieved this in two ways: first through documentary analysis and second by noting relevant comments made by each boundary spanner and senior stakeholder in the semi-structured interview. The researcher retrieved the

documents from multiple sources allowing the collection of a rich tapestry of interlocking information that provided the context for each case. In acknowledging that the reliability and validity of these documents are rarely perfect, the researcher used other supporting sources of data, such as comments made by the boundary spanner and senior stakeholders in the semi-structured interviews that either supported or cast doubt on the integrity of the documents.

To answer the first research question, the researcher used multiple data sources provided by the case studies to assemble information about the boundary wall and its properties. Each boundary spanner completed the PAT questionnaire by filling out a scoring sheet for each of the six partnership principles by either agreeing or disagreeing with six statements per principle. The boundary spanner assigned a score to each statement, and they were totalled for each principle. The boundary spanner could score between 6 and 24 for each principle. Hardy et al. (2003) provided meaning for the respondents' score for each principle, but as discussed in chapter 6.3.2.2, the researcher changed the granularity of the PAT analysis by combining the scores from two sections out of a total of six that measured the same property of the boundary distance wall. This process created results that were equated to the three properties of the boundary wall: height, width and hardness. Next, the researcher calculated the boundary wall by noting the difference between the relevant boundary spanners questionnaire scores. The greater the degree of divergence in overall scores, the more substantial the overall boundary wall. Semi-structured interview quotes coded positive (green) or negative (red) provided additional feedback to the scoring above. The researcher found that additional codes were needed to fully match what the boundary spanner said with the dimension used in the focused coding. These additional codes reflected the need to include the environment as part of the calculation to determine the permeability of the boundary distance wall.

To address the second research question, the semi-structured interviews from both the boundary spanners and senior stakeholders were coded to highlight and confirm all the different roles taken on by the boundary spanner when answering questions from the semi-structured interview. Using the descriptors provided by Williams (2012), the four role elements: reticulist; interpreter/communicator; coordinator; and entrepreneur most commonly employed by boundary spanners, were looked for in

the interviews. To help with the analysis, the researcher used the words describing the main competencies attached to each role to ensure that the researcher could thoroughly interrogate the transcripts. They were applied to the transcripts, and he noted the number of times the boundary spanner mentioned each role. A total for each role was calculated at the end of the interview. Finally, the researcher assessed the semi-structured interviews, the work history, induction, and the continuing professional development of boundary spanners to determine whether this impacted how they conducted their roles. The next chapter associates these empirical findings to the literature reviewed in this thesis.

CHAPTER 8 – DISCUSSION

This chapter links the empirical findings of the previous chapter to the literature reviewed in chapters 2, 3, 4 and 5. Additionally, it includes insights into new findings relevant to the boundary wall's conceptualisation, the roles played by the boundary spanners, and some methodological recommendations.

Section 8.1 uses the current PPP concepts derived from the literature analysis in chapter 3 to describe, understand and differentiate between the three NHS PPP case studies in this thesis. This analysis is important as the way the NHS PPPs are defined using the current literature will be compared to the enhanced descriptions of the case studies using the new boundary wall framework. The contention is that attention to the boundary wall offers valuable insights into the dynamics and processes of PPPs that conventional analysis may overlook. Sections 8.2 and 8.3 looks to link the findings from the PAT and the semi-structured interviews to discuss, confirm and enhance the literature from chapter 5. Section 8.4 relates boundary theory to results from the semi-structured interviews. Section 8.5 analyses the boundary spanners' behaviours and activities, including the roles they inhabit managing the partnership and the impact that their work history, experience, and training might play. Section 8.6 highlights additional methodological findings from the three case studies.

8.1 NHS Public-Private Partnerships

To describe and differentiate between the case studies, they are analysed using four approaches. The research from chapter 3 indicated that decisions made by the partnership impacted the way they operate. Each approach is discussed in turn.

8.1.1 Motivation to Partner

Chapter 3.1 explored the many potential motivations for organisations to consider a partnership. It highlighted both organisational and agential drivers and suggested that it depends on the particular circumstances of each partnership as to which are the most important. A valuable summary of the approaches potentially taken by organisations who may wish to partner is provided by Dickinson and Glasby (2010) and is reproduced below. The cases have been allocated to an approach most directly applicable to the motives deduced from the results contained in chapter 7.1.

TABLE 27: FIVE REASONS FOR ORGANISATIONS TO PARTNER

	Optimist	**Pessimist**	**Realist**	**Pragmatist**	**Mimetist**
Why collaboration happens?	Achieving	Maintaining or enhancing position	Responding to new environments	Partnership sounds like a positive concept, and it is hard for potential critics to argue against proposed changes	Becoming an automatic policy response to a problem – other people are doing it, and it seems to be generally expected
Key assumptions about other partners	Altruism	Seeking personal or organisational gain	Realise need to change as society changes	Other stakeholders may object if the real organisational drivers were ever stated	Although not quite sure about specific outcomes, working together in some way must surely be a good thing
Key factors at work	Role of charismatic leaders/boundary spanners	Power of individual partners and desire for survival	Ability to adapt to changing environment	Political and organisational drivers justified in terms of positive outcomes for and and/or service users	Desire to improve services, but imprecise and slightly naïve approach without being clear about desired outcomes
Case study fit	**WOS**		**IT**	**PATHOLOGY**	

Source: Adapted from Dickinson and Glasby (2010)

Considering the motivation to partner research, the optimist category for a PPP would seem unlikely. However, the WOS case study shows that it is possible. However, WOS is different from the other cases. The private company partner within the partnership is ultimately 100% owned by the public sector partner even though it operates as an arm's length organisation with its board of directors and governance structure. This provides for many freedoms and benefits for the management of the private company. WOS is not treated like any other private sector company by the trust as it is staffed by colleagues who have worked at the trust for many years. As mentioned earlier, the other line of research when it comes to drivers for partnership is agential. The potential of leaders and senior managers to influence the decision on partnership has been the subject of many theories. In this case, the composition of the board made a significant difference. This is confirmed in section 7.1.1.2, where positive remarks about the commercial attitude of the board were made by the boundary spanner and senior stakeholder of WOS.

The Trust had built up evidence of working successfully with private companies on many significant projects, so the rational choice theory incentive of shared monetary rewards and system-wide change seems applicable to this case. In chapter 3.3.3, Skelcher (2005) request for public managers to think very carefully before engaging with private sector companies is outlined. One of his main reasons is the difference he sees between the rhetoric of common interest concealing important differences of value and motivation. In stating this, he might not have considered that the boards of foundation trusts can be as commercial and business-minded as a private company. Hence, their values and motivations can be very similar, as in this case. In addition, Noble and Jones (2006) assert that in the initial stage of the partnership, there is a clear distinction between 'project champions' and 'boundary spanners' born out in this case. The trust board drove the decision-making process to ensure implementation, which they then handed to the boundary spanner (Respondent 6; Snr Mgr WOS).

The IT case fits somewhere between the optimist and realist approach, but it has been put in the realist column as the case displays more aspects from this approach than the optimist approach. The case was very encouraging as IT implementation in the NHS has generally been a disaster. The trust board approached replacing their

antiquated electronic patient system refreshingly differently and made some critical upfront choices. They decided on using open-source software rather than purchasing an off the shelf solution from a large supplier, an approach that had fallen into disrepute. The board also decided to appoint a clinical lead to ensure they obtained engagement from the clinicians right from the start of the project by involving as many as possible in the selection procedure. The rigorous procurement process meant that both organisations entered into the partnership with a clear set of aims and objectives and emphasised working together.

This case fits nicely into the strategic management narrative suggested by Buick et al. (2019). The Trust has recognised they needed to bring in another party to achieve the goal of a new IT system as they or the wider NHS did not have the expertise or capacity to deliver. There was an understanding that leveraging the skills of an IT partner required a more strategic approach to working across boundaries, irrespective of whether the boundary was public or private. From an agential viewpoint, selecting a consultant physician as the clinical lead for the trust and a very experienced IT implementation expert from the private company feels crucial. It is clear from their interviews that they were working toward the same aims and objectives, and they had the seniority and gravitas to drive the project forward. As in the WOS case, the trust board made the strategic decision as to who to partner with, and then they appointed a boundary spanner to drive the partnership forward. The second phase of the IT project is being implemented with the same private company boundary spanner but a different NHS boundary spanner. Although outside the scope of this thesis, it would be fascinating to analyse the differences in how this second phase has been implemented as it would provide some revealing data as to the impact of an individual boundary spanner.

PATHOLOGY doesn't fit entirely comfortably into any of the five approaches. Although it falls mainly into the pragmatist category, there was a political push to re-organise how pathology was structured in the NHS. However, the results chapter describes the NHS organisation entering the partnership with their eyes wide open by being very clear about what they wanted from partnering with a private company. A better fit for categorising PATHOLOGY is using Entwistle and Martin (2005) second proposition, which suggests that some organisations want to unlock specific

competencies of their perspective partner. This ties in well with the Audit Commission (2002) report that states working with business, public organisations have the potential to access new funds for capital investment, benefit from economies of scale and bring in managerial and technical expertise. One of the trusts involved with PATHOLOGY is the same trust that initiated the WOS partnership, with a similar board as described in the WOS case. It is not surprising, therefore, that a PPP solution was proposed and accepted.

It is important to allocate each case study a category for their motivation to partner as the literature has shown that it impacts how the partnership progresses. It shows that although the literature is comprehensive about why partnerships might form, it was still not easy to categorise all of the case studies. This finding is likely to tie in with NHS PPPs being different from that generally investigated in the research.

8.1.2 Modes of Governance

The literature reviewed in chapter 3.2.3 asserts that a network/collaborative mode of governance is associated with PPPs (Williams, 2002, Klijn and Teisman, 2003, Ansell and Gash, 2008) as it provides the most supportive environment for the PPP to flourish. This section discusses whether this is born out in the case studies. An adapted Powell (1990) model of markets, hierarchies and networks introduced in chapter 3.2 are the basis for the following analysis.

TABLE 28: MODES OF GOVERNANCE IN THE THREE CASE STUDIES

	Forms		
Key Features	**Market**	**Hierarchy**	**Network/Collaborative**
Normative Basis	Contract - Property Rights **, I, P**	Employment Relationship **W**	Complementary Strengths **P, I**
Means of Communication	Prices **W**	Routines **W, P, I**	Relational **W, I, P**
Methods of Conflict Resolution	Haggling - resort to courts for enforcement	Administrative fiat – Supervision **, P**	Norm of reciprocity – Reputational concerns **W, I,**
Degree of Flexibility	High	Low **P**	Medium **W, I**
Amount of Commitment Among the Parties	Low	Medium to High **, P**	Medium to High **I, W**

Tone or Climate	Precision and/or Suspicion	Formal, bureaucratic **P,**	Open-ended, mutual benefits **W, I,**
Actor Preferences of Choices	Independent	Dependent **W**	Interdependent **W, I, P**
Case study overarching mode of governance		**P**	**W, I**

Own Exhibit

W = WOS case; P = Pathology case; I = IT case

In terms of the *normative basis* of the partnerships, the market model consisting of a detailed contract and legal sanctions were dominant for the IT and PATHOLOGY cases at the start of the partnerships. However, as the partnerships have matured, the latitude to embrace complementary strengths developed with the progression of the IT and PATHOLOGY partnerships. Therefore, the normative basis of the IT and PATHOLOGY moved from market to network/collaborative. In addition, the normative basis for the WOS case is hierarchical as it is a wholly-owned subsidiary of the public partner. However, as it develops and potentially gains more external contracts, the normative basis may change in the future.

The WOS case features all three types of *means of communication.* A detailed price structure for each service indicates a market mode, while formal meetings to discuss key performance indicators (KPI) are in the hierarchical model. However, relational means of communication are also present in the partnership. The boundary spanners emphasised the importance of relationships and informal communication for the success of the partnership. For IT and PATHOLOGY, the formal and informal communication channels were important.

In terms of the *methods of conflict resolution,* the researcher can identify typical features of the network/collaborative model of governance in the IT and WOS cases. Powell (1990, p. 303) notes that individuals are 'engaged in reciprocal, preferential, mutually supportive actions' in networks. This is very much the way the boundary spanners of these two cases describe their relationship. Interestingly, the IT case has a market contract but is being managed in a network type manner. This description ties in nicely with the analysis of chapter 3.2.5, where Agranoff and McGuire (2001) postulated that the formal governance arrangements of the

partnership are not necessarily how it operates on a day to day basis. The P case solves issues by interpreting the contract but don't resort to external resolution. Hence it uses a hierarchical model of governance.

Powell (1990, p. 303) suggests that networks are 'lighter on their feet than hierarchies'. It is not surprising then that WOS and IT cases, where there is considerable scope to influence how the partnership delivers the contracted services, offer a greater *degree of flexibility* than PATHOLOGY, where the actors' flexibility is more constrained by the KPIs set out in the contract. However, in terms of *commitment* and *tone,* the particular circumstances of all three cases mean they act in a hierarchical or network type manner, rather than the market mode expected.

Two case studies, WOS and IT, confirm the literature that the 'network' form is the preferred choice of governance structure. Interestingly, the analysis demonstrates that PPPs can have different modes of governance. The research highlighted in chapter 3 argued that the mode of governance selected by the partnership could potentially affect the way the partnership is operated. For example, a market-orientated governance structure is likely to discourage partnership as actors prefer to be independent and are unlikely to fully commit to the partnership, picking instead to ensure their organisation is as successful as possible.

The hierarchical governance most often relies on rewards and punishments and involves formal management structures around the partnership. Partnership working is possible using this type of governance structure. Usually, it consists of drawing up a detailed contract with many KPIs and penalty clauses for non-compliance. The public partner likely has a higher status and more power than the private partner. From the analysis in table 28, the PATHOLOGY case generally fits with this description. However, the results from chapter 7 concerning the power of public organisations compared to private companies don't feel as one-sided as most researchers would describe.

The network/collaborative mode of governance arises because managers can identify complementary interests when entering a partnership (Lowndes and Skelcher, 1998). As a result, there is an interdependence between the organisations built on trust and collaboration. With the emphasis on mutual benefits, working together, and having the ability to resolve difficulties through informal channels, this

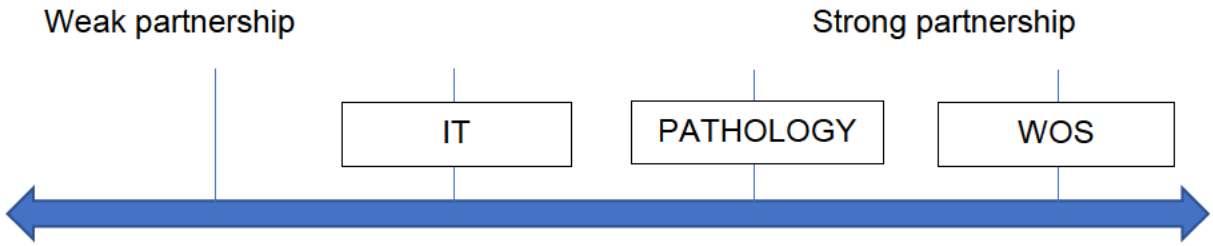
type of governance arrangement is well suited to the potential stresses and strains of working in a PPP. The analysis places the IT and WOS case studies into this mode of governance. These cases fulfil the requirements of Van Ham and Koppenjan (2001) PPP definition by cooperating in developing products or services and sharing the risks, costs and resources required to produce them.

This section has questioned whether having a governance structure other than a network means it can't be classed as a PPP. Therefore, it is important to see where on the PPP spectrum each of the case studies lies. This spectrum is the subject of the next section.

8.1.3 PPP Spectrum

This thesis postulates that an alternative way to understand and describe PPPs is to take the suggestion of researchers such as Briggs (2010), Dhillon (2013) and conceptualise PPPs as moving along a spectrum from weak forms of partnership to strong forms. In chapter 3.4, figure 3 proposed a spectrum for PPPs that went from contractual relationships that have little to do with partnership working through to strategic partnerships with very strong partnership links. This section adapts this generic spectrum to start at 'weak partnership' as previous analysis has shown that the three case studies in this thesis have partnership elements - figure 6 overlays where the cases are located on the spectrum.

FIGURE 6: PPP SPECTRUM



Own Exhibit

The IT case is contract-based and time-limited, but it falls within the longer-term partnering contract because it displays, as Klijn and Teisman (2000) have described, joint decision making to achieve effectiveness and build trust seen by them as crucial. PATHOLOGY is a contract managed by a special purpose vehicle (SPV). The case matches well the description of a joint venture (JV) by DCLG (2006), which

describes a JV as a strong form of partnership as it enables joint working, pooling of assets and the pursuit (if not successfully) of aims and objectives. WOS is the strongest partnership on the spectrum because it is a strategic partnership. It conforms to the definition of a PPP because it is an independent company with a separate board; both parties have a strategic input into the company's development and share the risks and rewards.

Comparing PPP spectrum analysis and the mode of governance analysis, it is interesting to note that the IT case has a weaker type of partnership arrangement yet has a strong partnership model of governance. Conversely, PATHOLOGY, a joint venture, a strong partnership arrangement, has a hierarchical mode of governance, seen as a more complex form of governance arrangement for PPPs. WOS conforms to the standard type with a strong partnership and network/collaborative governance model.

8.14 PPP Life-Cycle

Chapter 3 highlighted research that emphasised the time element or life-cycle of a partnership. The argument is that partnership working may be easier to achieve in some of its stages than in others. To comment on this strand of research, the three case studies have been graded using the 3 stage model suggested by Gray (1989). The WOS case, which had only been up and running for nine months when analysed for this thesis, is in the *direction setting* stage. The other two cases have all been up and running for at least three years when they became involved in the fieldwork is all in the *implementation* stage.

The case studies clearly showed the churn of senior staff to have an impact in two of the cases. In the WOS case, section 7.1.1.2, the senior stakeholder clarifies that key personnel changes within a partnership can significantly impact, especially at the board level. In section 7.1.2.2, the senior stakeholder in the IT case was very clear about how the working relationship deteriorated over the contract period.

This section has looked at four areas where the research in chapter 3 indicated current thinking around the process decisions made by partnerships that impact the way they operate. This thesis has proposed an alternative way to judge the impact of the processes adopted by a partnership. The contention is that attention to the

boundary wall offers valuable insights into the dynamics and operations of PPPs that conventional analysis may overlook. A discussion about this is the subject of the next section.

8.2 Properties of the Boundary Wall

This section discusses and updates the working propositions that flesh out the individual properties of the boundary wall *height*, *width* and *denseness* and proposes a new boundary wall property. It then addresses the overall strength of the boundary wall.

8.2.1 Height

The height of the boundary wall is composed of two key concepts; mutually agreed aims and objectives for the partnership and a well thought out engagement and communication strategy. The literature presented in chapter 5.2.1 and summarised in proposition 1 clarifies that it is crucial for the success of the PPP that its aims and objectives have been extensively discussed and agreed upon between the individual organisations making up the partnership. A good way of looking at the tension between the two is suggested by Kurr (2004), who states that the relationship between individual organisation objectives and partnership objectives can be symbiotic, harmonious or in conflict. Each concept is dealt with in turn.

> *Proposition 1: The greater the agreement of partnership aims and objectives by the individual organisations, the lower the boundary wall. Alternatively, the lack of shared goals and objectives between partnering organisations, the higher the boundary wall.*

The results of the PAT scores can be summarised by the PATHOLOGY partnership having a harmonious relationship, while IT and WOS can be described as symbiotic. This is an interesting set of results as the literature presented in chapter 5.2.1 points out that PPPs bring two or more organisations together, likely to have different and even conflicting objectives. The empirical findings of this research do not bear this out. The boundary spanners all felt a unity of purpose to the partnerships that bound the organisations together. One boundary spanner from PATHOLOGY said, '(I am) quite clear why (we) get a private company into the NHS'. In WOS and IT, the unmistakable sense of purpose for the partnerships is palpable. As a WOS boundary

spanner comments, 'there are many good reasons for the WOS, both financial and non-financial'.

A number of the interviews with senior stakeholders emphasised the importance of the selection process as one way of really understanding and bringing together the strategic intent at the beginning of the partnership. As one PATHOLOGY senior stakeholder said, 'having a competitive dialogue process was hugely important… you really got an opportunity to drill down into potential pathology partners'.

Huczynski et al. (2013) highlighted the importance of an effective partnership communication and engagement strategy for all relevant stakeholders. The proposition in chapter 5.2.1 reflected this facet.

> *Proposition 2: The better the engagement of and communication to partnership stakeholders, the lower the boundary wall. Alternatively, the less engagement and communication with partnership stakeholders, the higher the boundary wall.*

Trafford and Proctor (2006) research points to how employees of the individual organisations within a partnership can assume and also misunderstand the motives of each other, making it imperative that there is a comprehensive PPP communications strategy in place to ensure employee engagement. The scores for this proposition are on the low side for most cases and in part reflect that this aspect of the PAT focuses on monitoring, measuring and learning in the partnership rather than the actual communication process. However, the boundary spanners in the semi-structured interviews talked a lot about how information flowed between the partner organisations and how important it was to them. The asymmetry of information exchange in the PATHOLOGY case is striking. Both NHS boundary spanners complained about not receiving important minutes of meetings as they were deemed to be 'commercially sensitive'. As one commented, 'you do often feel like you're trying to make a decision with one arm tied around your back' and 'in terms of how we learn from mistakes, how we share best practice, how we take things forward, (it) doesn't feel very joined up. This was not picked up by the private boundary spanner, who felt the partnership was effective. The other interesting aspect of the empirical results is that the NHS boundary spanners in IT and WOS

were much more positive than their private counterparts about how the partnerships monitor, measure, and learn during the partnership process.

Overall, the empirical findings would suggest that both of these propositions are important for the performance of the partnerships. In the case studies, effective communication and learning are more important to the ongoing effectiveness of the partnerships than clear aims and objectives. This may be because the partners thrashed out the partnership's objectives in the initial forming stages and evident to all those involved in all three cases. Maybe one of the advantages of PPPs in the NHS is that the creation process is so long and tortuous, the aims of the partnership need to be crystal clear to all stakeholders for it to have a chance of being established.

8.2.2 Thickness

In chapter 5.2.2, Marks and Mirvis (1992) pointed out that when organisations have very different cultures and are brought together, it is likely to result in conflict. Mannion et al. (2011) identified several key differences in the cultures between public organisations and private companies that influenced the quality of the partnership. Reynaers (2014) research confirmed the stereotypical view of different public and private values but provided hope that it was possible that they could be blurred during partnership working. This analysis resulted in the creation of proposition 3.

> *Proposition 3: The smaller the cultural differences between the partnering organisations, the thinner the boundary wall. Alternatively, the greater the cultural differences between partnering organisations, the thicker the boundary wall.*

The research suggested that it is helpful to view how the cultures of the partnering organisations interact. This was achieved using three models presented by Meyerson and Martin (1987); the integration model, the difference model and the ambiguity model. The difference model is most applicable to PATHOLOGY because the model emphasises the importance of disparate cultures being held by different actors within the same organisation. It is clear from comments made by the boundary spanners and senior stakeholders that the pathology departments of each

Trust had independent cultures from each other and the rest of their organisations. For instance, one NHS boundary spanner said: ‘we have very strong personalities... so sometimes challenging some of those personalities is difficult'. This has an impact on the private company within the partnership and the other Trust. For example, the same boundary spanner commented, 'Historically there has always been a bit of competition between the two hospitals'. The other NHS boundary spanner commented, 'There is a pathology committee where the pathologists should all go. None of my pathologists will attend'. Thus, one NHS Trust perceives itself closer in culture to the private company than the other NHS Trust.

The integration model of culture is most applicable to the IT case. This characterises culture as something that organisations possess and is broadly similar across the whole organisation. Interestingly, the IT private organisation is a commercial organisation, which theory would suggest would mean a wide gap in cultures. Instead, the case demonstrated a close tie-up between the two cultures.

The ambiguity model is most suitable for the WOS case. The model suggests that culture is more local and regularly changes between groups within an organisation and between organisations. Due to the wholesale movement of individuals from a large NHS Trust to a subsidiary company, there was very little difference in the culture of the PPP organisations at the start of the partnership. This similarity was encouraged as the private boundary spanner states, 'from the start we really wanted to make sure that they were still feeling part of the trust'. However, moving forward, there have been efforts to create an independent culture in the private company. The private boundary spanner again 'what we've tried to then is instil that bit of WOS identity as well…different logo on jackets'. The public boundary spanner confirms this different culture 'and the people that have moved to WOS are proud to work for WOS'.

Overall, the empirical results would suggest that proposition three is important for the performance of the partnerships. Using the culture modelling offered by Meyerson and Martin (1987) has enhanced describing how different organisational cultures interact.

8.2.3 Denseness

The theoretical review in chapter 5.2.3 highlighted the importance of trust and power to how any PPP operates. Rose (1997) highlighted that the perception of power and trust balance between partners was important, while Bachmann (2001) suggested that power and trust are alternative ways of managing the partnership. Therefore, the partnership should be described as either exhibiting power relations or trust focused. The conclusion was that both trust and power operate in a PPP and impact how it performs. Therefore, the thesis proposed two working propositions, one that focuses on the trust dimension and the other on the power dimension. Proposition 4 stated:

> *Proposition 4: The greater the trust between stakeholders in the partnering organisations, the more porous the boundary wall. Alternatively, the greater the mistrust between stakeholders in partnering organisations, the more impenetrable the boundary wall.*

In the PATHOLOGY case, where they have reached the accommodation phase of the relationship, there is a significant discrepancy in trust. This is confirmed by the comments made by the NHS boundary spanners. It is in sharp contrast to the private boundary spanner and senior stakeholder who was optimistic about the trust in the relationship. In IT and WOS, the NHS and private company boundary spanners all express a positive level of trust reflected in the boundary wall's softness. Proposition 5 stated:

> *Proposition 5: The smaller the power differential between partnering organisations, the more porous the boundary wall. Alternatively, the greater the power differential between partnering organisations, the more impenetrable the boundary wall.*

The power differential between the NHS and private organisations in the PATHOLOGY case is apparent and has reinforced the sense of mistrust. Das and Teng (2001) suggest that power issues invariable within PPPs are not shown in other cases. The other two cases reflect a minimal imbalance of power between the organisations, so there is no amplification or reduction in the way trust is perceived.

The empirical findings confirm the working propositions that power and trust are important to the partnership. It is helpful to enhance the understanding of the wall

denseness by using the Boon (1994) analogy of relationships. Trust is key to how the partnership operates, with the difference in power accentuating whether trust can be built or diminished. When talking about power, many authors (Hardy and Phillips, 1998, Grimshaw et al., 2002, McQuaid, 2002) emphasise the unequal nature of the PPP relationship. Interestingly, this did not appear in two out of three cases, where the perception of power was similar.

This section has looked at the individual properties of the boundary wall and shown that there is value to looking at them in turn. The three individual properties of the boundary wall provide a new way of viewing key processes that each organisation brings to the PPP relationship. However, there were additional empirical findings found outside the concept of the three properties of the wall, and they are considered in the next section.

8.2.4 Fourth Property of the Boundary Wall

Chapter 2.6 explored several external reasons why some high profile PPPs in the NHS had failed. Using the framework suggested by Field and Peck (2004), the thesis concluded that they were one-off events that the researcher did not feel to be part of the ongoing partnership management process that the boundary wall intends to measure. In addition, chapter 3.1.1 outlined the research by Sullivan and Skelcher (2002), which highlighted the realist position for motivation to partner where the wider environment has an important part to play in determining the incidence of partnership formation. However, because the boundary wall occurs only when the partnership has formed, rather than in its planning stage, the researcher did not feel it necessary to include the external implications into the definition of the boundary wall.

In retrospect, these were wrong assumptions, as the comments recorded in chapter 7.2.3 demonstrates that the boundary spanners in all three case studies comment about the influence of the *environment* has an impact on the *ongoing* process of partnership working. They pointed out that changes to government policy around the use of private organisations and the financial constraints put on the NHS during the fieldwork were significant influences on how the partnerships operated in practice. Hence, the environment should be considered as a new element of the boundary

wall. Extending the wall analogy, the environmental factors are the foundations on which the wall is built. This conclusion leads to the following proposition:

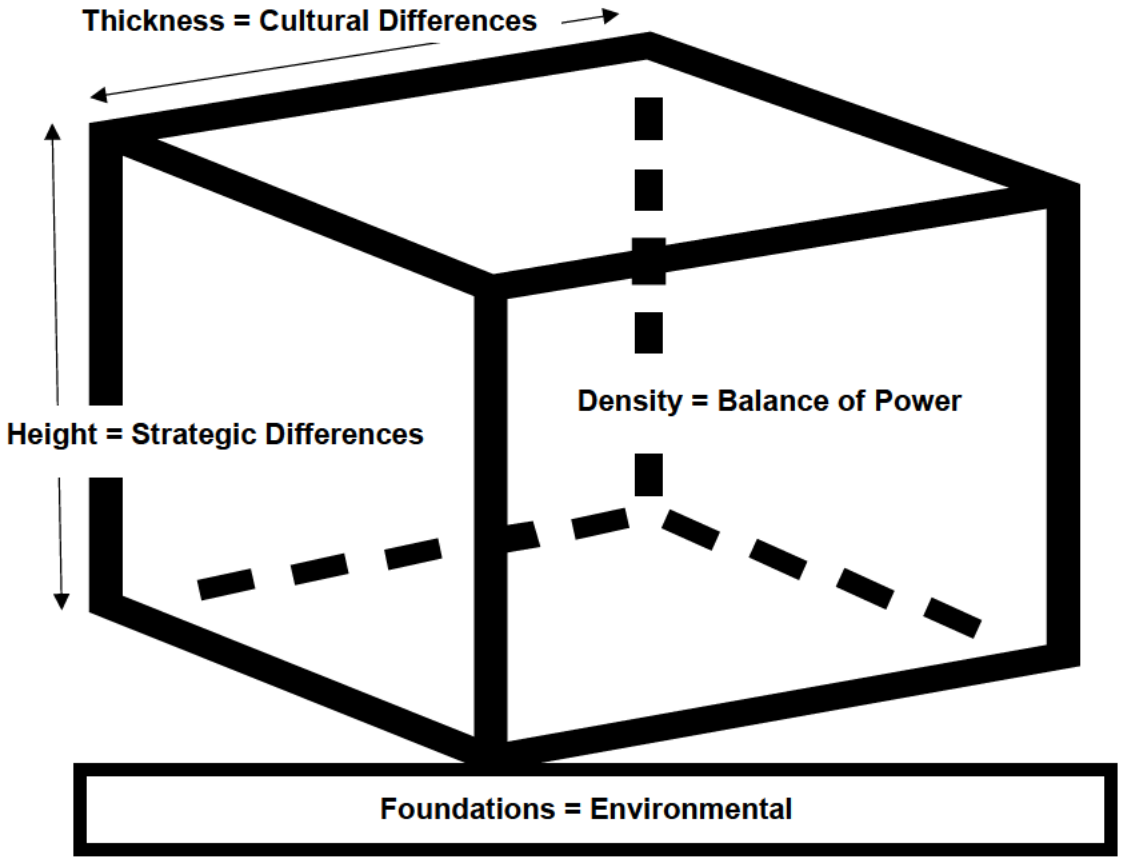
> *Proposition 6: The smaller the impact of ongoing environmental factors, the more unstable the foundations of the boundary wall. Alternatively, the bigger the impact of the ongoing environmental factors, the more stable the foundations of the boundary wall.*

There is difficulty measuring this fourth property of the boundary wall, as there are no environment questions included in the PAT. Therefore, it would seem sensible to either adapt the PAT to have questions about the environmental impact or include a specific section of quantifiable questions in the semi-structured interview to rate the sturdiness of wall foundations. One of the main criticisms laid at the door of standardised partnership assessment tools such as PAT by Halliday et al. (2004) suggests they inadequately capture the context-specific nature of partnership working. Using these additional questions should help mitigate this criticism. This thesis does not consider the form these questions would take, and it would be a valuable extension of the empirical work undertaken in this thesis.

8.2.5 Overall Strength of the Boundary Wall

This thesis has generated a new model for considering the impact of a boundary wall on PPPs, which has expanded and refined the initial model introduced in chapter 1 (see figure 1). This new model is set out below in the diagram below.

FIGURE 7: BOUNDARY WALL FRAMEWORK



The strength of the boundary wall depends on the differences between the partners on the four dimensions of the boundary wall shown above. Table 29 depicts how the differences or similarities between partners in strategy, culture, power and the environment can create a strong boundary wall or a weak boundary wall.

TABLE 29: VARYING STRENGTH OF THE BOUNDARY WALL

Dimension	Strong Boundary Wall	Weak Boundary Wall
Height	**Tall:** lack of agreed partnership aims and objectives	**Low:** shared partnership aims and objectives
Thickness	**Thick:** significant cultural differences between partners	**Thin:** small cultural differences between partners
Density	**Impenetrable:** large power differential between partners	**Porous:** negligible power differential between partners

Foundations	**Stable:** impactful environmental factors	**Unstable:** benign environmental factors
Result	Communication, collaboration and teamwork between partners harder to achieve	Communication, collaboration and teamwork between partners easier to achieve
Implications for Boundary Spanners	Increased difficulty of enacting effective boundary spanning roles. This means that the role of boundary spanner may need to spend more time engaging key stakeholders at the expense of other relevant activities	Increased ease of enacting effective boundary spanning roles. This means that the boundary spanner has to expend less energy and time on bridging the different partners and can focus on ensuring all aspects of the partnership run smoothly

Own Exhibit

As discussed in chapter 5.4, Jeffares et al. (2013) demonstrated that the PAT was an excellent proxy for determining the overall strength of the boundary wall framework. To understand whether this provides additional insights into how an NHS PPP operates in practice, it is sensible to compare the results from the new framework with analysis from current literature.

As the boundary wall measures the difference between the organisations, the larger the number, the greater the wall strength. For example, PATHOLOGY had the strongest wall with 25, WOS on 16, and IT with a weak wall on 1. In addition, the PAT can assess the absolute partnership strength by aggregating the scores from all the sections of the questionnaire. For example, PATHOLOGY had a total score of 99, and WOS and IT were similar but with substantially stronger partnerships scores of 125 and 128. To understand what these numbers mean in practice, they are compared to analysis in previous sections. The results are shown in Table 30 below.

TABLE 30: COMPARING THE CASE STUDIES USING STANDARD FRAMEWORKS AND THE NEW BOUNDARY WALL

Case study	Motivation to partner	Dominant Governance arrangement	PPP spectrum	Stage in life-cycle	Boundary wall strength	Aggregate score (36 -144)
PATHOLOGY	Pragmatist	Hierarchy	Medium-strong	Implementation	25	99 - The partnership is working well enough overall, but some aspects may need further exploration and attention
WOS	Optimist	Network	Strong	Direction setting	16	125 - The partnership is working well
IT	Realist	Network	Medium	Implementation	1	128 - The partnership is working well

Own Exhibit

There is a good fit between current partnership descriptors for the PATHOLOGY and WOS and the thesis analysis. The former case hierarchy governance and medium-strong partnership suggest a problematic boundary spanning management task, reflected in the strong boundary wall and a medium aggregate PAT score. On the other hand, a network governance structure and strong partnership imply a more straightforward boundary spanning in the latter case. This analysis is shown in a weaker boundary wall and a positive aggregate PAT score.

The IT case is seen as a solid partnership, but using current descriptors, some boundary panning roles would be challenging. However, this is not shown in the analysis with a very weak boundary wall. A very positive aggregate partnership score on the PAT would indicate that this is a very smooth running partnership requiring minimal boundary spanning interventions to ensure the partnership is effective.

These results show that the boundary wall framework provides additional insights into how each partnership's management task for boundary spanners can be viewed. In two of the three case studies, the management task would seem to fit with current descriptors. However, in the other case study, the ongoing management tasks for boundary spanners would seem to be less demanding than expected.

8.3 New Propositions

This section discusses the empirical findings which are not within the scope of the boundary wall framework. Hence this section pinpoints areas where additional research would be fruitful based solely on the empirical results.

8.3.1 Additional Organisations Within the Partnership

In PATHOLOGY, a second foundation trust, with a separate board of directors, is part of the PPP. There were some hints from the current NHS boundary spanners that there had been significant tensions between the two Trusts as described in section 7.1.4.2. In this case, the boards agreed on the PPP's aims and objectives, and over time boundary spanners ensured that the partnership has endured.

However, both the private company boundary spanner and senior stakeholder highlighted another PPP where the two NHS organisations did not work well together it caused objective problems for the PPP. A limitation of the research is that the thesis has focused on the properties of the boundary wall between the public and private organisations. This is not surprising as, during the literature review for chapter 3, no research was found about the impact of additional organisations being part of a PPP. It can only be assumed it was for one of the following reasons:

- It is a very uncommon type of PPP, and therefore no researcher has come across it
- It is not thought to impact the success or failure of a PPP

The summary by NHS England (2019) shows that when it comes to the NHS pathology reorganisation, combining two or more trusts with a private company is more common than a 1 to 1 relationship. However, it is clear from comments made by the boundary spanners and senior stakeholders that there are additional complications when additional organisations form part of the PPP. Therefore, when considering a PPP with more than two organisations, research should assess the

boundary wall between each of the organisations. The interplay between the two public organisations is also likely to impact boundary spanners behaviours and activities. This finding offers a fruitful research agenda for future academics.

8.3.2 Creating a Boundary Wall as Strategy

WOS is a fascinating case because a boundary wall has been erected as a deliberate strategy to produce two separate organisations, a public organisation and a private company, to create a PPP. Sheaff et al. (2019, p. 05) propose that boundary repositioning (or in this case boundary creating) 'may stimulate internal changes in managerial regime'. They go on to suggest that there are three main assumptions about how the managerial regimes differ in private and public organisations:

> '(1) (Private organisations).. have proportionately more managers, especially finance managers (Aidemark and Lindkvist, 2004). Conversely, the 'public firm' structures and management practices developed in NHS Trusts increased the proportion of 'strategic' managers but not specialist managers. Indeed, NHS Trusts had a smaller (and decreasing) proportion of managers compared with the whole UK workforce (Kirkpatrick et al., 2017) (a pattern possibly over-reported by reclassifying clinician managers to claim reduced NHS 'bureaucracy' (Hyde and Exworthy, 2016)).
>
> (2) Less formalised, standardised, 'bureaucratic' managerial procedures ('red tape'), hence quicker completion of managerial tasks (Bozeman et al., 1992), and less risk-averse, more entrepreneurial (inventive, innovative, flexible and risk-taking) decisions.
>
> (3) To mount stronger managerial challenges to restrictive practices and other 'bureaupathologies' (Thompson, 1977) and faceless pressure to take a short-term perspective in decision making'.

All three of these assumptions are born out from the empirical findings in this case, although as the PPP had been formed only nine months ago, it is too early to comment on whether the decision making was now less short-term. However, the comments of the private sector boundary spanners who had moved to the private companies when the PPPs were formed were instructive. One said, 'actually there is

a lot less red tape, it is a lot easier……I much prefer this side of the fence rather than the NHS side'. The other boundary spanner commented 'we don't know...feel constrained by thinking the NHS has to do it in a particular way' And the WOS senior stakeholder commented 'in terms of accountability for Estate Management services it has been a real success. So now we've got loads of different KPIs, which we monitor on a monthly basis'. For these private company boundary spanners, the change in mindset came from moving from an NHS organisation to a private company that made such a positive impact. They were now part of new organisations that were smaller in scale, narrower in focus, and liberated from the extensive rules and regulations that have grown up over the years dictating how NHS organisations operate. For these individuals, moving organisations had removed the shackles, and they were embracing freedom.

Sheaff et al. (2019, p. 12) et al concluded that:

> 'Our findings also call into question the practice of copying managerial techniques across the public-private boundary, and the idea that repositioning that boundary is purely 'back-end' change, without consequence for health policy outcomes'.

The empirical evidence from this case study confirms that it is not correct to assume repositioning a boundary only leads to cosmetic changes, but the findings do not agree that this means it is not a good idea to try repositioning. Although in the early stages of the PPP, the analysis of the boundary spanner and senior stakeholder comments has shown the erection of the boundary wall has stimulated several positive changes:

- Smaller and nimbler organisation created
- Tighter controls
- Ability to make a difference
- Increased performance measurement

Further investigation as to the benefits and pitfalls of producing a PPP out of one organisation (particularly an NHS one) through the creation of a boundary wall would seem to offer a productive avenue for the NHS to adopt and provide a rich research agenda for future academics.

Sections 8.2 and 8.3 have linked the empirical findings from the PAT and the semi-structured interviews to discuss, confirm and enhance the literature from chapter 5. The boundary wall framework is a valuable construct in understanding how the policies of each organisation create a wall when a partnership between them is established. This wall has four properties: foundations, height, thickness, and denseness. The dimensions of these properties are determined by the similarities and differences between organisations in terms of environment, strategy, culture, and power. It is the contention of this thesis that the overall strength of the wall impacts the behaviour and activities of the boundary spanners involved in managing the PPPs under investigation. This is the subject of the next section.

8.4 Boundaries, Boundary Work and Boundary Leadership

The research on boundaries provided an understanding of some of the issues that arose from the case studies. The private IT senior stakeholder explicitly mentioned that relationship difficulties arose when a new project head was appointed and didn't want to spend as much time on-site as he had. So the physical boundaries suggested by Hernes (2004) can be more than just physical impediments; it can be the actual lack of a physical presence that has an impact. In addition, his suggestion of social boundaries has resonance in all three case studies. For PATHOLOGY and WOS, the partnering company was formed from colleagues of the other partner. All boundary spanners and senior stakeholders of these cases reported that this made a significant difference to how relationships between the partners developed as they already knew each other, and ‘bonding’ had already occurred before partnership formation. In addition, when considering Hernes (2004) description of mental boundaries, the fact that all five organisations in these cases were managed by people who had all worked in the NHS was significant. In the IT case, the extensive selection process allowed positive group dynamics to develop, which was taken into phase 1 of the project. Personal chemistry also seemed to play a positive and negative role. As per Pouthier (2017), the private IT senior described how he and his opposite number in the NHS Trust 'worked well together, we bounced off each other, we had a similar lens on life and achievements ,and frankly, a similar sense of humour'. Conversely, both senior stakeholders in the IT case remarked that people from both organisations found it difficult to discuss issues with the private boundary spanner.

All three case studies support Carlile (2004) description of boundary work outlined in sections 4.1.1 and 4.1.2 about transferring and translating knowledge. Transferring knowledge was seen as a crucial role for all boundary spanners and the senior stakeholders of each partnership. What was also apparent was the importance of both the formal and informal ways in which boundary spanners transferred knowledge. Emphasis was placed on their ability to anticipate problems and flag them up before they became an issue. The cases showed that there was an expectation that boundary work required the translation of knowledge across boundaries, but the ability to do so depended on the boundary spanners own view of their role and also their abilities to do so. Both NHS Trust boundary spanners' descriptions of their responsibilities within PATHOLOGY showed they felt their main boundary work was to transfer rather than translate knowledge. In the IT case, the senior stakeholders both felt the lack of ability of the private company boundary spanner to translate knowledge to and from each partner successfully caused problems in phase 2 and phase 3 of the project.

The importance that boundary leadership in general and agent-orientated (section 4.2.2) in particular can have on a PPP was brought into sharp relief by the change to the board's composition in the WOS and IT cases. At the initiation stage, each PPP had a board committed to doing the partnership. They were composed of dynamic and visionary leaders who overcame considerable external resistance to make them happen. However, when the composition of the boards changed due to the passage of time and some of the original leaders left to be replaced by others who weren't there at the start of each PPP, the partnerships started to run into problems. For example, in the case of IT, the new chair wanted to explore other suppliers, which began to damage trust. In WOS, the board started to express doubts about the business model and whether it was acceptable to have different terms and conditions for Trust employees.

8.5 Boundary Spanners

Chapter 1 outlined the research questions being considered by the thesis, the second of which asked: ‘Does the composition and hence the permeability of the boundary wall impact the roles and behaviours of boundary spanners?’ This section assesses the empirical evidence and considers three additional antecedents that

potentially have an impact on boundary spanner behaviour. Each is considered in turn.

8.5.1 Compare and Contrast Roles Played by Boundary Spanners Depending on the Strength of Boundary Wall

To assess whether the strength of the boundary wall influences the behaviours and actions of the boundary spanners, the semi-structured interview transcripts were evaluated for the four role components that Williams (2012) identified as the most commonly employed by boundary spanners. The researcher then contrasted these with the strength of the boundary wall, and the results were summarised in chapter 7.3. It is difficult to say on these results whether the boundary wall impacts the specific roles played by the boundary spanners. Interpreter/communicator is the most common role, and that is irrespective of the wall strength. On reflection, the small number of summary roles considered meant that it was likely to be difficult to discern a definite pattern. However, it is apparent that when assessing how boundary spanners describe their roles as a whole, there are substantial differences in emphasis, which does reflect the strength of the boundary wall. The NHS boundary spanners in PATHOLOGY were the most critical of how the partnership was operating. One disagreed with the statement that the partnership is achieving its aims and objectives. This case has the strongest boundary wall. Respondent 4; Snr Mgr IT coupled with the NHS IT boundary spanner's reported comments were both optimistic about how the partnership operated, emphasising how easy it was to work together and how supportive both organisations were in driving the project forward. It is not surprising, therefore, that the PAT calculated the boundary wall as almost non-existent. The third case, WOS, was assessed as having a medium strength boundary wall, which was perhaps a little surprising given the generally very positive comments from both the NHS and private boundary spanners. This finding might well reflect the short time that the partnership had been established meaning some of the partnership processes had not had time to bed down.

The summary from this analysis is the difficulty of the boundary spanner job increased as the strength of the boundary wall became bigger. The empirical findings did not indicate that the wall changed the boundary spanners' actual roles to perform, just that they were harder to enact. Further research where the granularity

of the boundary spanner role is increased could provide more significant empirical confirmation of boundary spanner role changes.

8.5.2 Compare and Contrast Roles Played by Boundary Spanners Depending on Type of Organisation

Chapter 4.2 discussed the two strands of literature that provided the most insights into boundary spanners' behaviour and roles: IOR literature and public collaboration literature. It was noted that while research on inter-organisational forms is a large and growing strand of the management and strategy literature (Cropper, 2008), research on PPPs as a particular type of inter-organisational form is treated predominantly in the public policy literature (Joyner, 2007). This finding was born out in the literature review where most research was found in the public collaboration domain and in particular when it comes to discussing the roles and competencies of boundary spanners on the management of partnerships the research of Williams (2002, 2005, 2012) has had a significant impact. However, this leaves the question of whether the introduction of private companies into the partnership relationship has a discreet effect on the roles and actions of boundary spanners, which is separate from that described by Williams and the boundary wall? As pointed out in Chapter 7.3, it is fascinating to see that all three NHS boundary spanners display no entrepreneurial role elements.

In contrast, two out of three private company boundary spanners exhibit strong entrepreneurial roles, with the third one presenting occasional entrepreneurial role elements. This result suggests that the type of organisation impacts the way boundary spanners conduct their managerial roles. Of course, this empirical result might only apply to NHS organisations that have a powerful public sector ethos where entrepreneurship is not encouraged. Still, this finding is at least a warning that researchers should not assume that the way boundary spanners manage in the partnership can be divorced from the way their home organisation influences them.

8.5.3 Work History, Training and Experience

The literature reviewed in chapter 4.2.2 (Williams, 2005, Miller and Stein, 2020) highlighted that boundary spanners' previous work history, training, and job experience could potentially impact boundary panning behaviour. Therefore, the following section assesses the empirical evidence from the three case studies.

8.5.3.1 Work History

Both boundary spanners in the WOS case study have worked in the private sector and the NHS. They felt that this increased their effectiveness with one stating: ‘I think having worked in the private sector, that’s contributed a huge amount’ and the other saying: ‘and then coming back into the NHS, I’ve got that wealth of experience that other people don’t have. I can actually see it from the private providers side of things’. This theme is also present in PATHOLOGY. The private company boundary spanner and senior stakeholder had worked in the NHS before moving to the private sector. It feels like this NHS history is important to the partnership working relationship. As one NHS boundary spanner commented: ‘It’s kind of easier in a way because we see them and there is still that NHS understanding’. They can all relate to each other's past work experience, and two interesting questions arise. Does this shared NHS connection affect the cultural differences of the two organisations, which is reflected in the width of the boundary wall? Secondly, is this effect more significant if the boundary spanners from all organisations in the partnership have a shared public/private work history? Even if further research points to this being important, the IT case study shows that it is not crucial, as the boundary spanners have no shared work history yet could relate to each other and participate in an excellent working relationship.

8.5.3.2 Selection and Training

Considering the potential additional skills highlighted in chapter 4, table 11 that boundary spanners need to bring to their roles, recruitment to become a boundary spanner seems more random than planned. The boundary spanners previous or current job in their organisation was the criteria for selection rather than any particular selection procedure or innate skills they possessed to carry out the boundary spanning role. However, even though the selection procedure was no different, all boundary spanners in the case studies struck me as very competent. They added to the viability of the partnerships by their professionalism and conscientiousness. This was even more impressive considering the lack of training and preparation for the boundary panning roles at induction and onwards. For instance, the NHS boundary spanner in the PATHOLOGY case study confirms 'there's never been any dedicated training for working with a partnership organisation in pathology. I could have done with some. This supports the research of Osborne

(2010), as discussed in chapter 4.2.2.1. What they have all managed to do is learn on the job; 'I will continue to do what I have done over the past five years and that is learn', stated one boundary spanner, and this was a common thread running through all their accounts. A lack of formal training opportunities has been counteracted by a desire to learn on the job. That desire to thrive in a demanding job may partly explain why nearly all of them have been boundary spanners since the partnership inception or for a significant length of time. This section has highlighted the potential influences on the behaviour of boundary spanners. Empirical evidence confirmed that the permeability of the boundary wall impacts the performance of the boundary spanner, but it is not possible to say exactly how it changes the combination of roles that they play. In addition, the evidence points to organisation type and work history having an impact. Although the evidence is incomplete when it comes to selection and training, it feels that the willingness to learn and adapt on the job is as important as any innate personal characteristics they may have.

The discussion in this chapter so far has been framed by interpreting the empirical findings outlined in chapter 7. However, by the very nature of conducting three case studies as part of this thesis, several methodological findings have also materialised. These are discussed in the next section.

8.6 Methodological Findings

The empirical evidence consisted of three main strands: understanding the background and establishment of each partnership through collecting background documents, filling out the PAT questionnaire, and conducting semi-structured interviews. The latter two aspects provided some methodological insights, which are outlined below.

8.6.1 PAT

8.6.1.1 Online Delivery

The PAT, created in 2002, was a paper-based questionnaire designed to be completed face to face. Chapter 6.2.2 considered the pros and cons of moving the questionnaire to online completion. New technology and bespoke questionnaire packages have made this process much less time consuming and as discussed, brings many potential benefits. When first administered as an online tool to the test participants in a trial, it was found that very few completed the questionnaire. On

reflection and in discussion with participants, there were three issues using this online data collection method. The first issue was that all participants were very busy. Although they found time to talk with the researcher, the participants felt the additional time to fill out the questionnaire at a different time to the interview was onerous. The second issue was that the questionnaire, although transferred accurately to the online environment, felt repetitive when looked at on a screen. Some questions seemed to be asking the same thing unless read with attention and care. This meant some participants did not complete the questionnaire at one sitting and then did not go back to complete it at another time. The third issue was with the technology. Some internet providers blocked or placed the email with the unique link to the questionnaire into the spam folder. It was not seen until sometime after the telephone discussion, meaning participants lost the impetus to complete the questionnaire. The subsequent change to face to face completion ensured a 100% completion rate.

This experience is a reminder that even though online technology enhances the reach and application of questionnaires (some of the original participants were hundreds of miles away), it does not always guarantee satisfactory results. From this experience, it is recommended that researchers should give additional thought to using questionnaires in a personal rather than impersonal setting.

8.6.1.2 Granularity of PAT Scoring

Some researchers (Halliday et al., 2004, Petch, 2008, Ball et al., 2010, Tsou et al., 2015) either discussed the use or used adapted PAT in their research papers. There was general agreement that the tool was useful but that the scores that it produced needed additional data to ensure that the results were not misinterpreted. For instance, Halliday et al. (2004, p.301) provide a good summary of the general conclusion from the papers:

> ‘In contrast, this article has demonstrated repeatedly that turning the resultant ‘score’ into meaningful learning is dependent on the availability of supporting data. As a stand-alone device partnership assessment tools are thus open to misinterpretation’.

As well as agreeing with this point (the comments before and during the completion of the PAT by the boundary spanners provided invaluable context to their answers),

the thesis identified an issue with the actual scoring of the PAT. It concluded that the scoring needs to be more granular and less favourable. Even when the respondent rates five out of six statements as disagree and one agree, it pushed the overall section into a positive description. It is recommended that before future academics use what is a very useful tool, they assess the scoring and adapt it to ensure that the answers for each section accurately reflect the sentiment expressed by respondents.

8.6.2 Semi-Structured Interviews

On researching what coding schematic should be used for the semi-structured interview manuscripts, it became apparent that it was possible to use them for a dual purpose. Each transcript could provide data for both research questions as the boundary spanner on talking about their role within the partnership also added context and clarity to the properties of the boundary wall, whether consciously or unconsciously. This insight meant that the thesis created two schematics, and each transcript was coded twice. This provided double the empirical evidence for the same amount of time spent with each recipient, a recommended innovation where it is felt appropriate.

8.6.3 Dual Perspective

As discussed in section 6.10, obtaining interviews from senior stakeholders allowed alternative and independent viewpoints on how the boundary spanners in each case study performed. It was beneficial for two reasons. First, the senior stakeholders backed up the boundary spanners description of their role within each partnership. This finding provided reassurance that the boundary spanner interpretation of their roles and responsibilities could be seen as reliable. Second, as these senior stakeholder interviews were conducted sometime after the boundary spanner interviews, it was possible to obtain a life-cycle perspective on each case study. This revealed that the situation of two out of the three case studies had significantly changed over the intervening time.

8.7 Conclusion

This chapter has explored the validity of the boundary wall concept and its effect on the roles of the boundary spanners across the three case studies and related these to wider conceptual and policy debates. First, having reviewed the literature around NHS PPPs, it indicated four areas (motivation to partner, modes of governance, PPP

spectrum and PPP life-cycle). The research in chapter 3 showed that process decisions made by partnerships impacted the way they operate. This was important as the way the NHS PPPs are described using the current literature were compared to the descriptions of the case studies using the new conceptual boundary wall framework. The following section discussed and updated the working propositions that fleshed out the individual properties of the boundary wall: *height*, *thickness* and *denseness*. It showed value to looking at them individually as it provided a new way of viewing key processes that each organisation brought to the PPP relationship. Comments recorded in chapter 7.2.3 demonstrated that the boundary spanners and senior stakeholders in all three case studies commented that the influence of the *environment* has an impact on the ongoing process of partnership working. They pointed out that changes to government policy around the use of private organisations and the financial constraints put on the NHS during the fieldwork were significant influences on how the partnerships operated in practice. This tied in with research explored in chapter 2.6, where several external reasons why some high profile PPPs in the NHS had failed, and chapter 3.1.1, which outlined the realist position for motivation to partner where the wider environment has an important part to play in determining the incidence of partnership formation. Hence, the researcher felt it necessary the environment be considered a new element of the boundary wall. To extend the wall analogy, the environmental factors are the *foundations* on which the wall is built.

As discussed in chapter 5.4, the literature showed the PAT to be a good proxy for determining the overall strength of the boundary wall framework. To confirm whether this provided additional insights into how an NHS PPP operates, it was sensible to compare the results from the new framework with analysis from the current literature. As the boundary wall measures the difference between the organisations, the larger the number, the greater the overall wall strength. PATHOLOGY had the strongest wall with 27 and 23, then WOS on 16, and IT with a very weak wall on 1. In addition, the PAT indicated partnership strength by aggregating the scores from all the sections of the questionnaire. The PATHOLOGY score of 99 was somewhat different from the WOS and IT case studies which had substantially stronger partnerships scores of 125 and 128.

Table 29 in chapter 8.2.5 showed there was a good fit between current and the thesis analysis of partnership descriptors for PATHOLOGY and WOS. PATHOLOGY has hierarchy governance and medium-strong partnership, which suggests a complex boundary spanning management task. This is reflected in the strong boundary wall and a medium aggregate PAT score. WOS has a network governance structure and strong partnership, which implies straightforward boundary spanning management. This is shown in a weaker boundary wall and a positive aggregate PAT score. The IT case is seen as a solid partnership, but some aspects of the boundary panning roles would be difficult using current descriptors. This is not shown in the analysis with a permeable boundary wall. A very positive aggregate partnership score on the PAT would indicate that this is a very smooth running partnership requiring minimal boundary spanning interventions to ensure the partnership is effective. These results showed that the boundary wall provided additional insights into how researchers could consider each partnership's management task for boundary spanners. In two of the three case studies, the management task would seem to fit with current descriptors. However, in the other case study, the ongoing management tasks for boundary spanners would seem to be less demanding than expected.

To assess whether the strength of the boundary wall influenced the behaviours and actions of the boundary spanners, the researcher compared the boundary work research identified in section 4.1 to the empirical findings. These broadly backed up the research into the importance of boundary spanners being involved in knowledge transfer and translation and how changes to boundary leadership can be disruptive to partnership performance, but the boundary wall could not quantify this effect. In addition, the semi-structured interview transcripts were assessed for the four role components that Williams (2012) identified as the most commonly employed by boundary spanners. The results were inconclusive as to whether the boundary wall impacts the specific roles played by the boundary spanners.

Interpreter/communicator is the most common role, and that is irrespective of the wall strength. The small number of summary roles considered meant that it was difficult to discern a definite pattern. However, it was apparent that when assessing how boundary spanners describe their roles as a whole, there are substantial

differences in emphasis, which does reflect the strength of the boundary distance wall. The NHS boundary spanners in PATHOLOGY were the most critical of how the partnership was operating. One disagreed with the statement that the partnership was achieving its aims and objectives. This case had the strongest boundary wall. Respondent 4; Snr Mgr IT coupled with the NHS IT boundary spanner's reported comments were positive about how the partnership operated, emphasising how easy it was to work together and how supportive both organisations were in driving the project forward. It is not surprising, therefore, that the researcher calculated the boundary wall as nearly porous. The third case, WOS, was assessed as having a medium strength boundary wall, which was perhaps a little surprising given the generally very positive comments from both the NHS and private boundary spanners. This finding might reflect the short time the partnership had been established, so some of the partnership processes had not had time to bed down. In summary, the boundary spanner job became harder as the overall strength of the boundary distance wall increased. The findings did not indicate that the wall changed the essential roles the boundary spanners needed to perform, just that they were harder to enact. Further research where the granularity of the boundary spanner roles is increased could provide greater empirical confirmation of boundary spanner role changes.

The literature reviewed in chapter 4.2.2.1 and 6.3.4.2 highlighted the fact that the previous work history, training and on the job experience of the boundary spanners had the potential to impact boundary spanning behaviour. The empirical evidence points to organisation type and work history having an impact. When it comes to selection and training, although the evidence is incomplete, it felt that the willingness to learn and adapt on the job was as important as any innate personal characteristics the boundary spanner may have had.

This chapter has discussed a number of themes that have been derived from conceptualising the boundary wall framework. The next chapter pulls the many threads together in order to summarise the key contributions to knowledge of the thesis.

CHAPTER 9 - CONCLUSIONS

This thesis has reviewed the history of private sector involvement with the NHS, the role and management of partnerships, and PPPs' hybrid nature. A key research theme to emerge was that organisational (reviewed in chapter 3) and agent factors (reviewed in chapter 4) were crucial to achieving partnership success. Unfortunately, alternative strands of PPP literature have been investigated in silos rather than joined together. This problem led to thinking about how the researcher could combine them. It inspired research that focused on the considerable differences in organisations before they join together to deliver a product or service. The thesis postulated that the current analysis had overlooked the significance of these differences. It was helpful to think of the boundaries of each organisation in the partnership needing to be bridged so that the two or more organisations combined to create one entity, the partnership. There was extensive literature that discussed boundaries, boundary objects, boundary spanners and boundary work (reviewed in chapter 4) but not the boundary wall. This framework examines both sides of the coin by recognising the bridge or wall between organisations has implications for how boundary spanners carry out their roles and activities. The framework is proposed and discussed in the thesis (chapter 5) and is a significant original contribution to the overall literature on boundaries.

Chapter 6 considered all the primary research designs before the researcher adopted a comparative case study approach. It was reasoned that the comparative case study would best answer the research questions and contribute to an under-researched and under-theorised area – and, despite the limitations recognised in section 6.2.6 – this has proved to be the case.

The requirement to create a framework meant, as mentioned in chapter 1, a slightly unusual balance to the research as the conceptual contribution takes up a larger than normal portion of the whole thesis. However, without developing the 'boundary wall' framework, it would not have been possible to investigate the dynamics between organisations in the PPP thoroughly. In addition to this crucial conceptual contribution to knowledge, the thesis makes original empirical and methodological contributions.

9.1 Original Contributions to Knowledge

9.1.1 Conceptual Contribution to Knowledge

This thesis found there was extensive literature that focused on partnerships between public-public organisations and private-private companies. There was significantly less literature that discussed partnerships between public-private organisations. However, this thesis has shown that choosing judiciously between the theoretical approaches, a summary of the partnership literature as it applies to PPPs (in general) and the NHS in England (in particular) is possible. The majority of the literature clarifies that effective partnerships need a combination of structural and agent factors to work in harmony. Although finding few examples that use PPPs as case studies, the researcher found the roles and behaviours of boundary spanners to be well researched. However, what was lacking was literature that investigates the effect of organisational boundaries when they pertain to PPPs. The thesis, therefore, took as its focus the boundaries that separate organisations within a PPP. The existing literature focuses on boundaries, boundary objects, boundary spanners and boundary work but does not discuss to any great extent the boundary wall between organisations. By framing the interaction of organisations at their boundaries as a 'boundary wall', the thesis explored how the changing permeability of the boundary wall impacted the roles and activities of boundary spanners. The permeability of the boundary wall changed depending on four elements of the organisation: environment, strategy, culture and power.

The researcher assigned each of the wall properties to a dimension: how 'stable' the wall foundations was dependent on the environmental factors; how 'tall' the wall was dependent on the strategic fit of the organisations; how 'thick' the wall was dependent on the cultural fit between organisations; and how 'dense' the wall was dependent on the power distribution between partnering organisations. This thesis further postulated that the overall strength of the boundary wall had a direct impact on the ability of boundary spanners to manage the partnership. If the environmental factors for the partnership are harsh, the strategic and cultural fit are weak, and there is a power imbalance, then the strength of the boundary wall will be significant. This strong boundary wall will make the boundary panning job difficult, with the outcome likely to be a challenging partnership. In contrast, suppose the environmental factors are positive, the strategic and cultural fit is strong, and the power imbalance is slight.

In that case, the boundary wall is weak, and the boundary panning job is much easier, and the partnership is more likely to run smoothly.

9.1.2 Empirical Contribution to Knowledge

As the composition and permeability of the boundary wall change, the roles and behaviours of the boundary spanners change. The results are inconclusive as to whether the boundary wall impacts the specific roles played by the boundary spanners. Interpreter/communicator is the most common role, and that was irrespective of the wall strength. The small number of summary roles considered means that it is difficult to discern a definite pattern. However, it is apparent that when assessing how boundary spanners describe their roles as a whole, there are actual differences in emphasis, which do reflect the strength of the boundary wall.

Chapter 4 highlighted the influence of Williams (2002, 2005, 2012) on the discussion about the roles and competencies of boundary spanners. His research is predominantly focused on public-public partnerships, which begs the question of whether the introduction of private companies into the partnership relationship has a discreet impact on the roles and actions of boundary spanners, which is separate to that described by Williams and also the boundary wall?

As pointed out in Chapter 7.3, it was fascinating to see that all three NHS boundary spanners display no entrepreneurial role elements. In contrast, two out of three private company boundary spanners exhibit strong entrepreneurial roles, with the third one presenting occasional entrepreneurial role elements. This suggests that the type of organisation impacts the way boundary spanners conduct their managerial roles. Of course, this might just apply to NHS organisations that have a robust public sector ethos where entrepreneurship is not encouraged. Still, this finding is at least a warning that researchers should not assume that the way boundary spanners manage in the partnership can be divorced from the way their home organisation influences them.

Compared to current research descriptions, this thesis affords insights into how onerous the ongoing PPP management task for boundary spanners is likely to be. In addition, the evidence from the case studies suggests that the type of organisation within which the boundary spanner resides, and their work history impact the way the boundary spanners conduct themselves.

The formation of the NHS PPP in the WOS case study was achieved by the deliberate erection of a boundary wall to produce two separate organisations, one a public organisation and one a private limited company. Critics could argue that this case study is not a PPP but the creation of a subsidiary. As outlined in chapter 6.6.4, the private company is overseen by an independent board that provided a level of separation from the NHS Trust that justified its definition as a PPP. In chapter 8.3.2, the analysis of the boundary spanner and senior stakeholder comments interviews showed that the creation of the boundary wall stimulated several positive changes: a smaller and nimbler private company was created; management implemented tighter financial controls; there was an actual ability for the management team of the private company to make a difference, and there was increased performance measurement.

9.1.3 Methodological Contribution to Knowledge

9.1.3.1 Online Delivery

The PAT, created in 2002, was a paper-based questionnaire designed to be completed face to face. Chapter 6.2.2 considered the pros and cons of moving the questionnaire to online completion. New technology and bespoke questionnaire packages have made this process much less time consuming and, as discussed, brings many potential benefits. However, some problems arose from moving the questionnaire online. The researcher's experience reminds us that even though online technology enhances the reach and application of questionnaires, it does not always guarantee satisfactory results. Therefore, it is recommended that academics give additional thought to using questionnaires in a personal rather than impersonal setting.

9.1.3.2 Granularity of PAT Scoring

The scoring of the PAT needs to be more granular and less positive. For example, even when the respondent rates five out of six statements as disagree and one agree, it pushed the overall section into a positive description. It is recommended that before future academics use what is a valuable tool, they assess the scoring and adapt it to ensure that each section summary accurately reflects the sentiment expressed by respondents.

9.1.3.3 Semi-Structured Interviews

On researching what coding schematic should be used for the semi-structured interview manuscripts, it became apparent that it was possible to use them for a dual purpose. Each transcript could provide data for both research questions as the boundary spanner on talking about their role within the partnership also added context and clarity to the properties of the boundary wall, whether consciously or unconsciously. This insight meant that the researcher created two schematics, and each transcript was coded twice. This process provided additional empirical evidence for the same amount of time spent with each recipient, an innovation that is potentially useful for future academics.

9.1.3.4 Dual Perspective Interviews

Chapter 6.10 identified research that highlighted the desirability of different perspectives on how managers carry out their job roles and responsibilities. Therefore, the fieldwork included interviewing both the boundary spanners and senior stakeholders who were their managers or regularly came into contact with them. This dual perspective provided additional reassurance about the boundary spanner interviews' integrity and increased the insights reported in chapter 7 and discussed in chapter 8.

9.2 Further Research

9.2.1 Creating a Boundary Wall as Strategy

Further investigation as to the benefits and pitfalls of producing a PPP out of one organisation (particularly an NHS one) through the creation of a boundary wall would seem to offer a productive avenue not only for the NHS to potentially adopt but offer a rich research agenda for future academics.

9.2.2 Additional Organisations Within the Partnership

In PATHOLOGY, a second Foundation Trust, with a separate board of directors, was a partner in the PPP. There were several hints from the current NHS boundary spanners that there had been significant tensions between the two public organisations and not just between the public and private organisations within the PPP. This view was reinforced by Respondent 1; Snr Mgr Pathology, who commented in his interview that he had an experience of another PPP where he found significant partnership issues because the two NHS Trusts did not work well

together. When considering a PPP with more than two organisations, it is suggested that the boundary wall between each of the organisations be assessed. The interplay between the two public organisations is also likely to impact all boundary spanner behaviours and activities. This finding offers a fruitful research agenda for future academics.

9.2.3 Boundary Wall Applied to Different Partnership Types

The boundary wall was conceptualised using literature specific to NHS PPPs. As it frames the forces between organisations in a partnership, irrespective of whether they are public or private, there seems to be no reason why academics cannot apply it to all partnerships. It is assumed that public-private partnerships, in general, will have stronger boundary walls than public-public or private-private partnerships. Investigating how the boundary wall's overall strength varies depending on partnership offers an exciting research agenda for future academics.

9.3 Research Limitations

This thesis was empirically limited to three case studies from the English NHS. The other three countries of the United Kingdom have taken different reform paths, particularly with regards to public-private partnerships. The findings of this thesis may resonate with all four countries but is only directly applicable to the NHS in England. Geographical location, the quality of management teams, the history of the particular service, the financial position of the NHS Trust and the surrounding local health economy, and the current performance of the service are all variables that could not be measured. They could potentially impact the findings from the case studies. The four summary boundary spanner roles might not have been granular enough to tease out slight differences in the way they performed their management duties depending on the permeability of the boundary wall. In hindsight, not to include the potential environmental impact as part of the boundary wall in the initial analysis was wrong. This was corrected in chapter 7.2.3 where a fourth property of the wall, the foundations was included and then discussed in 8.2.4. There were also additional limitations of a case study approach and the use of the Partnership Assessment Tool discussed in section 6.2.6 and 8.6.1.2, together with the rationale for choosing these approaches and the mitigations employed to reduce these potential limitations.

9.4 Implications for Practice and Policy

The literature points out that the scale of the task needed to create a successful partnership is often underestimated, none more so than in a PPP. The thesis aimed to investigate ways in which NHS PPPs could be more effective. It found that research often focused on independently assessing the organisational and agent requirements for PPPs. However, by linking four key partnership descriptors (strategy, power, culture and environment) to the properties of a boundary wall it focuses practitioners' attention on how to build better partnerships.

The thesis suggests that better partnerships can be achieved by reducing the strength of the boundary wall thus allowing for easier communication, collaboration and teamwork to flow within the partnership. In particular, the *height* of the boundary wall can be reduced by synchronising strategy and communications between the partners. The *thickness* of the wall can be reduced by recognising the differences in culture between the partners and putting schemes in place to bring them closer together. The *density* of the wall can be reduced by understanding the power imbalance and mitigate this by building and nurturing trust between the partners. The *foundations* can be weakened by being aware and responding creatively to any environmental factors impacting the partnership. By creating and then applying the boundary wall framework, this thesis has generated a series of insights for academics, practitioners and policymakers into how the dynamics between organisations directly impact the success of the PPP.

Implications for practice

- It is possible to unleash talent, entrepreneurial spirit and creativity within NHS organisations when partnerships with the private sector are managed effectively
- Initiators of partnerships could usefully focus on minimising the difference in strategic intent, culture and power within partner organisations, perhaps by using the PAT questionnaire to understand and then work on these issues
- There needs to be recognition that the challenge of creating effective partnerships is made harder when NHS and private organisations are involved, as the cultural differences might be expected to be greater

- It is important to allocate appropriate time and resources when selecting and training boundary spanners
- There needs to be acknowledgment of the crucial role of boundary spanners in creating successful partnerships by providing adequate resources and recognition
- Failure to take the strength of the boundary wall into account can reduce the likelihood of a successful NHS PPP compounding the general negativity surrounding their use

Implications for policy

- This thesis has produced a model (see Chapter 8.2.5) to use when seeking to promote PPPs
- Partnerships between the NHS and the private sector can be successful – this may seem a basic point, but is important in light of the criticisms that are often levelled at policies which promote PPPs
- Adequate focus must be given to the boundary conditions of organisations that are intending to partner – simply exhorting partners to work together or appointing a person to work across the boundaries are unlikely to be successful without more careful consideration of the nature of the boundaries which we are seeking to bridge

While this thesis has focused on NHS PPPs, it is possible that the boundary wall framework could be applied to other types of partnerships and in other sectors – with potential to improve the success rate of a broader range of partnerships. In this day and age where partnership working is seen as a necessity rather than a luxury, this is an exciting prospect.

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APPENDIX 1 – CODING SCHEMATIC

The coding highlights in different colours where the boundary spanner talks about the different properties of the boundary distance wall. Statements about the height of the wall (strategy dimension) were highlighted in yellow; statements about the width of the wall (culture dimension) were highlighted in green; statements about the denseness of the wall (power dimension) were highlighted in pink; and statements about the environment were highlighted in blue.

DA: Could you give me a brief outline of your NHS career from maybe 10 years ago to becoming involved in the Joint Venture?

FR: I was a diagnostic radiographer and I've worked my way up through different departments as a diagnostic radiographer and came to Trust 2 in 2006 as the superintendent radiographer and was the deputy manager. And then when my predecessor left in 2012, I applied and got this job. I've been doing this for very nearly six years. I've been in Trust 2 for over 12 years now.

DA: You have seen some changes?

FR: Just a few

DA: And in terms of getting involved with the partnership, when did that happen?

FR: I became radiology manager in December 2012. In the beginning of 2014, they asked me to take on the pathology management as well. I've been doing that for five years now.

DA: And did you get any training at all or any advice or anything around working in the partnership?

FR: I didn't get any training as a Radiology manager. Well, that's not true. Historically, we are quite poor at training our managers but we're getting better at it. Particularly here. We've had more dedicated management training. I've been on at least one leadership course since I've become manager. But no, there's never been any dedicated training for particularly Pathology or working with a partnership organization in pathology. And I could have done with some. What happened was the person that managed pathology before me was the private patient manager. And she wanted to hand it over and she left the trust a little after anyway, but she literally just handed over to me. I accompanied her to one what was then the operational board meeting - it is changed now. It's now their analytics board, but I went to one meeting with her. And then that was kind of it and it's all yours. Here you go.

Introductions to the current Operating Officer for partnership company. I met him and that was pretty much it.

DA: So how did the relationship develop then?

FR: Honestly, I would say that the relationship with partnership company as in their side that becomes the COMPANY joint venture because you do understand the structure…that has developed over time. It has been a learning curve, a steep learning curve. I neglected to say I did have some, a little bit of training from my finance account manager in the finance side of pathology because that's my role is predominantly to pay invoices that are YDH. I managed the pathologists and the pathology secretaries. And that's pretty much it. Except for everything that fell down the gap in the joint venture that we all forgot. And that is the biggest problem. There were lots of things that fell down the gap. And it was like, oh, What about that? That's not included is it? I think going forward it you know, if the NHS is going to do this, there needs to be a clear-cut kind of template of how to do it and what not to forget.

DA: I assume a lot of it was covered in the contractual basis or are you saying that the bits that fell down, were the bits that weren't in the contract?

FR: How frank can I be with this and where else will this go outside?

DA: It will not go anywhere else, absolutely not.

FR: The contract is rubbish. It was a very, very poor contract, even though it was written by legal teams. It was written by people without pathology knowledge. The manager that wrote it was a nurse and this is where it became really difficult because the staff with the knowledge of pathology got TUPE'd into COMPANY and so became in there and that's caused the real issues. TUPEing out of the NHS is quite upsetting for most people. Obviously in terms and conditions in the NHS are a lot of the reason why NHS staff work for it. It's very upsetting for staff to be told one day you are moving. Their choice was either do it or leave. I think they did lose quite a few although it happened just before I took over a year before I took over, so I wasn't completely ofay with it. All the knowledge of pathology was TUPE'd into the company and so the staff were unhappy, meaning they couldn't really gain that knowledge from the staff for the contract. While they got most of it right, there were some gaping holes that have led to issues. You know, ever since really, so, that is a major downside. I think that obviously being one of the first, as they become more and more common, if they become more and more common, they should improve.

DA: So, how have you overcome those issues? And is it mostly you that has to overcome them?

FR: Yes. although obviously I have to sometimes use my directors because sometimes it is way above my level. I would argue we have overcome some of them with time. And we have not overcome them all. Some of them still exist.

DA: Does that cause you tensions?

FR: Huge tensions. The problem is, I feel partnership company, the company, are commercial and obviously they need to be commercial and they do not understand how the wheels of the NHS work.

DA: It's interesting considering a lot of them are ex NHS?

FR: They don't understand how finances in the NHS work, that you know financial planning happens. We're just starting to plan for the next one financial year now. You cannot just drop a bill on the NHS and say pay it, it doesn't work like that. If we're not expecting it, we don't have the budget for it they say but we've stopped charging you for this. It's like, it doesn't work like that in the NHS and that has caused tensions in the past. Commercial contracts the way that commercial companies work, just pilots, it feels that they look at us they see something, think we want to do that. Just charge it to them. And it's kind of like its public money, you just can't expect the NHS to react like that. It can't, it doesn't do it, we have to be accountable. We have to prove what we're spending public money on. And they get quite tense about that. And quite angry. It's really, really difficult. You know, and, and it's not at the grassroots level, you know, I mean, D and J, ex NHS if you cut them open you're probably still find NHS inside them, but they are governed by commercial, so they can't be. And you know, it's never their fault. As its never commercial partners fault never. Something's happened. Some things go wrong, you know, never their fault! Whose fault is it then. It's really hard. You know, the NHS has a duty of candour, and we are a blame free culture. We admit our faults we say we have to. I know historically not always, but now we're quite good at it. We say that it's our fault. It does make it a challenge when, when your partner does not do the same.

DA: Have you changed the way you've managed that process over the six years?

FR: Yes, definitely. Recently we felt that the change in their staffing structure hasn't really helped as well. The CEO left two years ago, and we definitely have had a more strained relationship with partnership company since then. Because he was the one that set it up, you know, and he knew. It was a different manager at Trust 1 at the time and me, so we worked probably together for about two years and developed a better relationship. And of course, the guy went and then we had like three or four different ones in quite short succession. And then the MD went and so myself and my counterpart in Trust 1, she's been doing it for over a year now. And the new COO has been doing it for over a year and I've probably seen him twice in that time.

DA: You see D more?

FR: Oh, yeah, D and J. They seem to have taken over the role of the MD used to do. I mean, I didn't know D's face until probably a year ago now I see him all the time. Which is great. It's kind of easier in a way because we see them and there is still that NHS understanding. So yeah, it's kind of better in that way. We've lost the kind of commercial side of it. And we are at a point where we're pushing back on some of the commercial stuff now. We, about a year ago, coming up to a year ago, realized that we were almost kind of being divide and conquer. We felt we were being separated from Taunton. And I met with Helen my counterpart and we were kind of like, same problem. And I had one issue with a member of staff, who is Trust 1 and IPP joint, very challenging member of staff and I finally had the courage to say to Trust 1. He's a nightmare. And she went, that's exactly what I feel so I thought thank God for that. We had a quite a challenge. And that's when we realized we wouldn't be divided. And so we've worked much close together. We meet monthly now, myself and Helen, my director and her director and we meet every month. Talk about the issues before the directors go to the board. Because I've been to the board once. Wow. And I'm quite a strong woman. I've never been snowploughed quite so much in my life - absolutely flattened. Literally, 'and moving on'. Are we? Oh Okay, then. Properly got moved on, which I was not used to. It was quite a challenge. And the director had said before, the board was, basically they felt, an hour of partnership company telling them how fabulous they are. We were like that's not quite how we feel at operational level. You know? So yeah, we work much closer with Trust 1 now to push back.

DA: There wasn't so much of that contact?

FR: No none whatsoever. I thought radiologists were difficult until I met pathologists. They are quite challenging. Not all of them, but particularly the ones at Trust 1 are challenging. Definitely we feel, I might be wrong, that they feel distinctly superior to the Trust 2 pathologists despite the fact that our turnaround times always been historically so much better than theirs. And so there is a disconnect between them, which is nothing to do with COMPANY really. It's just to do with two groups of historically there's always been challenges between Trust 1 and Trust 2. Always think they're better than us. We always think we're better than them. Yeah, we are smaller they're bigger, but we think we do stuff better. You know, it's standard, across quite a lot of NHS areas. Yeah, you know, two hospitals competing for activity it can be. So yeah that's not helped so they don't gel well. Then COMPANY is trying to sort of say, because pathology is a really hard specialty to recruit to, they were saying that you need to work closer together. And this is sort of things, the hierarchy, hierarchical kind of meeting structure that feeds into different meetings really difficult. There is a pathology committee where the pathologists should all go. None of my pathologist will attend. It's a pathology committee with just Trust 1 pathologists. And the head pathologist, who is also in the partnership company. Yes, he has to be

asked every time which hat are you wearing? And things will come out of that. I didn't get the minutes for the meeting neither did my counterpart. So things were sort of coming out of that. And then we wouldn't know about them. And then it would go to the board, which is now called the Facilities Board. And they were quite clever at kind of taking a nod because it used to be our chief executive go and sometimes he still does, but taking a nod from them as that okay, we can do that.

We would be emailing them. Did you agree to do this? No, well why are we doing it, they said Paul has agreed this and he's like, No, no, it was discussed, and we went well that sounds good. And it's that's kind of relationship. If they have discussed it at board and, you know, the CEOs or the director would go, sounds good, good idea. All of a sudden, that was rite of passage and they would go with it. We're like, really? Digital pathology was absolute classic on this, which ended us up with a huge bill. Who signed this off? Nobody. Your CEO did. Paul, did you? No. But they want to charge us £40,000 now. And it got quite heated when we said we haven't got that.

DA: Do you think, just listening to you talk about Trust 2 and Trust 1, that some of the issue around Carter is that actually trying to combine hospitals into hubs just brings those issues to the fore?

FR: Obviously. We've seen some changes recently with STP work. Carter sort of recommended it at first. And then the STPs came along two years later and the STP proposals to start with were nonsensical, but all of a sudden there's been quite a bit of movement, definitely in the County partly because we've got a change of CEO who's very much we'll get engaged with our partners or we put ourselves at risk. We are working much more jointly with our partnership, you know, the Somerset partnership and the CCG as well because no matter what we do, there's no money. You know, because we're all kind of like put it back to the CCG but they have no money and the council haven't got any money. We understand that we're all in it together as there's no point fighting over the same pot when there's no money in it. We might as well try to work a bit smarter. But there are still heavy levels of push back. Trust 1 aren't performing quite as well as we are in rtt cancer and A&E performance. Well then if Trust 2 get a bit worse and we're like, No, no, we don't want to get worse at anything we will help support you try to get better. There's some real challenges and that's the sort of thing that, you know, you put a private company in the middle of all that. And it's the one that's got the more money that starts to take over. And it can't be like that in the NHS. And It is a real challenge. I mean, if we were flush with money, I think probably private enterprise with the NHS would work much better.

DA: Well, you saw that, 2012 when there was money things were happening. Well, it's expensive to partner, isn't it?

FR: It's a challenge. I'm glad they say that it's supposed to save us money. I'm not sure. It's hard to gauge because activity has gone through the roof everywhere. Yes, they put a hub lab in the middle of the county for bloods, you know? Yeah, that's got to be saving, GP bloods go there. I absolutely get economies of scale that has to be more efficient than having a lab here and a lab in Trust 1. But with the inflation that they have put on, we overspend every year we need to recharge it back to the CCG, you know, there is an element of our own work, Trust 2 work, that that we're over and above. So yes, we go over but there's also an element of the CCG work. And because we're on a block we don't get paid for it. And we need to be able to push back because otherwise why we're doing it we need to be able to say. You know what? You work directly with them yourselves because we're just losing money. And it's not small amounts. I think the financial situation has not helped. You know, it doesn't promote working with a private partner because they have to work for the biggest profits that they can, and we have to say, we don't make a profit out of this, we haven't got anything to give you. It has made it difficult.

DA: How do you think your role will change in the next two years?

FR: I don't think it will particularly change in the next 2 years. This is it. We always have motion in the NHS which are so slow. Again historical, there is no end date on the contract that we're aware of. I mean, would we ever come out of it? I can't see that we would because I can't believe coming out and going back to two separate little laboratories would be financially stable, but there is, you know, we're now looking at the contract of wherever the factors are when it can be renegotiated. Definitely in the contract it was after five years they had to do benchmarking to assess their prices. It just hasn't happened. To get them to do that is absolutely like pulling teeth out of a saber toothed tiger. It is damn near impossible. Well, we can't do that you know, this was at the board I went to - it is down to the Trust to do that, the debate was closed off - No, no, oh no, we agreed an audit by the trust. I'm kind of like, secret email, I don't think it is us is it? I can't get them to do a benchmarking exercise to see what their prices are like. There's nothing to compare us to it is like you know, really difficult. So, the wheels of motion for the NHS are so slow I don't see it changing in the next two years at all.

DA: Do you see the way you operate at all will change?

FR: I will continue to do what I have done over the last five years and that is learn. Google everything, because this is it, myself and my counterpart at Trust 1, neither of us are pathology trained. I'm a radiographer. I've learned so much about pathology now. And there's still so much to learn. Helen is exactly the same. I'm not even sure she's got clinical background. I'm not even sure she's a nurse. She might be I don't know what her background is, but she's a manager. So if it's clinical at all, it's nursing. No pathology at all because we will be having a Skype meeting and then we'll be emailing and saying what's that test? And some of its really confusing is kind

of like HPV Yeah. Is that the same as chlamydia? No. And you're googling all the different things. I think, again, not down to COMPANY's fault, but they have failed to deliver what they thought they could deliver, which was to pull in so much more business. And that's for a number of reasons, definitely not one is there lack of effort, they have absolutely tried everything. They tried everything they possibly could to get more business and got blocked at every turn.

Other NHS Trusts not being as brave as we were to get involved. Our neighbouring Trust the other way in Dorset, people marching through the streets at the thought of losing pathology to an outsourced company. They had a sit in and everything so that you know, they got close with quite a lot and then it would be like they weren't brave enough to do it. But now NHS England won't support them. There's, I can't remember exactly what, its either HPV or it's some cervical testing is falling over in the South West. Cornwall has fallen over, and we have been doing work for Cornwall for quite a while. And so, COMPANY, beautiful the work with NHS England invited bids for the work went to it, said we could do it. Got rejected. And it's kind of like we're doing what you told us to do. and you are kicking us out!

DA: Impressive that you went to went along together, though.

FR: We got told about it, obviously it came through the board and they wanted to do it and we said, yes, they think they can do it. Because I think NHS England want to centralise cervical screening and it puts their stuff at risk. They're desperate to centralize. And they desperately said, look, we're bid for it. And we've got kicked out with no real reason for it. You know, it's just kind of like no, so I can understand their frustration. I mean, they are growing elsewhere. They've got labs over in Southend and the Christie in Manchester, they are growing, but they're not growing anything that gave us the huge profit share that we were always going to get as part of the COMPANY company. And, you know, and I don't know if it's coming around again, it might be because I think they are in discussions with some places. They're desperately trying. Will it come off? Really frustrating for them because it was quite clear get them into the NHS, absolute prime example why would you have one lab in Trust 2 and one lab in Trust 1 doing the same thing know when you put one in the middle all centralized, faster, automated. And one group of staff instead of duplicating them.

DA: Maybe that will be the impetus for change, staff shortages?

FR: I would have thought a major thing because I'm presuming it's the same for biomedical science, radiography, nursing, physio all allied health have all had funding stopped through NHS England. HEE do not fund the courses. We used to get bursaries. That has all stopped. So now to become anything, and I would imagine it is the same for biomedical science you have to do your own student loan. So, when you know you're going to come out as a band five nurse starting on 22,000

pounds or 25 it's gone up to you're going to start paying off your loan straightaway. The appeal has gone down and, we've lost all the mature learners, mature students, it's kind of like where am I going to, you know, how am I going to pay that off? Because they all used to get it paid for? So no huge, huge dip already in recruitment most allied health professionals, it will be the same for biomedical science especially as a bit like us very hard to progress. It's not a rapid career move up the you know, so that might do it. that might do it. I mean, one of the benefits of the company with their overarching companies, they came and stole an awful lot of Spanish. Took a lot of Spanish staff and brought them over. They did have their benefits. But yeah, it might it might go back to it. But who knows? I can't see it being a rapid you know, all these trusts jumping on board.

DA: If other Trusts do come on board, you will get some profit share?

FR: Yeah, definitely. That was the whole point. We get a small profit share now but it's nothing compared to what was anticipated. If we can get all the work but I can honestly say it was not through lack of trying. Christ, they tried they were in discussion they will get so far and then they would get kicked out. I know why it can be a challenge because of the commercial side. But it's what they wanted us to do.

DA: But the wind has changed, hasn't it?

FR: Yeah, at the moment, we'll see. I think it could change because there's no money in the NHS to do anything. In the world of radiology, we are looking at managed equipment services from outside companies, and that's where everyone is going. Because there's no capital left in the NHS. It's gone, long gone. You know, ours went ages ago. Most other trusts have lost theirs, so you've got no big money to spend on anything. Particularly in pathology, radiology, the kit costs a lot. And it's got a limited life, you know, and even though you can eke it out for a while quality assurance, as you know, and it's, it's hard enough in radiology I would imagine quality assurance and blood analysers is absolutely nailed down for a lifetime and once it gets to it, you've had it, Things I did not know. I did not understand that pathology has two sides blood sciences and histopathology. And how you have to do quality assurance on all of those machines and how they have to go through external quality assurance. We don't have external quality assurance for radiology, we have duplicate reporting, audit, we don't offsite audit. It's all internal. 10% of all of our work is discussed at MDT. They audit each other's work. But we don't send a batch of images out to another hospital to do reporting to make sure that we are correct. But in pathology they do. And that was a real ummm and that was one of the major drawbacks that we've just fallen out of recently was oestrogen receptor testing in breast cancer.

And we had an EQA fail, which company started to immediately investigate, but didn't tell us at the time. Now, when you talk to the company, it's kind of like, well,

they have no time and they can happen. You know, it's not necessarily our work that's failed, it could be the control sample. But of course, it didn't come back into the trust. It's turned around that there was potentially an issue. Although on the most bizarre test I've ever seen in my life. Kind of the most subjective testing for this - it is a breast cancer receptive to estrogen hormone. And you can have - Yes. No. or somewhere in the middle. That's somewhere in the middle is absolutely down to the eye of the beholder. And have so far coming around the country and people aren't agreeing so think the only thing you would say with this test is either it's receptive or it's not. Or it's something in the middle. But because it didn't come back into the Trust quite as quickly as they were expecting to - drama. And things like that. EQAs fail all the time, you know, blood science EQAs they often get chucked out, you know, rejected, rejected, rejected, but they'll do it again, and then it's accepted and it's just kind of a blip as far as I am aware. So we have got much a better, more robust process in place, you know, because they were like more we did tell, we did say in the in the SMG meeting, it was like, well, that would be me and I wasn't there. So it's just gone down in the minutes as an EQA blip. And it wasn't until later which could have been a major potential issue which has been resolved, but you know, but the knowledge has walked out of the building. You know, most of the historical staff, it's only the pathologists and they don't talk. Bit better now that I poke them now. It has its challenges.

The interview then moved onto filling out the questionnaire.

DA: Second to last question, which of the six areas of partnership is the most important?

FR: Well, I would say trust is really important and it's what's lacking.

DA: Now final – to what extent do you agree with the following statement in respect of the partnership as a whole which is the subject of this assessment – the partnership is achieving its aims and objectives?

FR: I agree. It could be improved but it is definitely achieving our goals, the pathology services are working.

APPENDIX 2 – REQUEST FOR PARTICIPATION LETTER

UNIVERSITY OF BIRMINGHAM

School of Social Policy

Dear

Subject: Participation in PhD research project investigating partnership working

I am writing to invite you to participate in my PhD research project being conducted in collaboration with the University of Birmingham. Agreement has been given by the Hospital Director to approach you. The purpose of the project is to research the relationship between private companies and their NHS partner at several different sites. Each partnership will be assessed across several metrics to see how close or far apart they are to each other and then the impact that this distance has on the roles and responsibilities of staff who manage the relationship will be explored. The results of the fieldwork will be written up in a confidential report offering a common language for partners to discuss both the opportunities for developing more effective working and the perceived barriers to this happening.

To elicit your views, I would like you to complete a questionnaire that has been widely used and validated in numerous studies on partnership working. The information provided by you will be used for research purposes only. It will not be used in a manner which would allow identification of your individual responses. You can withdraw from the Study, with a written request, within six months of taking part and will not be asked any questions about why you no longer wish to participate. The Study has been considered by the Ethics Committee at the University of Birmingham and has obtained full ethical approval.

If you agree to participate in the research, can you respond to this request by emailing me at [redacted] I will then send you more details about the research which will include the questionnaire with instructions on how to complete it. Thank you very much for considering this request.

Yours sincerely,

Duncan Alexander PGCARMS MBA BA

PhD Researcher, University of Birmingham

APPENDIX 3 – PARTICIPATION INFORMATION SHEET

UNIVERSITY OF BIRMINGHAM

School of Social Policy

31st January 2019

Dear ,

Participation Information Sheet – Semi-Structured Interview and Questionnaire

Thank you very much for participating in this PhD Study being conducted on behalf of the University of Birmingham. This Information Sheet explains what the study is about and how I would like you to take part in it.

The purpose of the research is to analyse the relationship between the NHS and private sector companies when they work together. The primary aim of the fieldwork is to measure how different the organisations are to each other and explore the impact that this difference has on the role of employees involved in managing the partnerships.

To elicit your views, I would like you to participate in a semi-structured interview. The interview will take approximately 45 minutes to complete. A rough guide to the interview is, first we will discuss your background and how you came to be selected for this position, we will then look at your current role and responsibilities in managing the partnership, then how you think this has changed since you started in the role, and finally, we will end by looking at how you think this role might change in the future. A partnership questionnaire will then be completed.

The information provided by you participating in the interview will be used for research purposes. It will **not** be used in a manner which would allow identification of your individual responses.

At the end of the Study, anonymised research data will be archived at the UK Data Archive to make it available to other researchers in line with current data-sharing practices. You can withdraw from the Study, with a written request, within six months of taking part and will not be asked any questions about why you no longer wish to participate.

The study has been considered by the Ethics Committee at the University of Birmingham and has been given a favourable review.

Once again, I would like to thank you for taking part in this Study. If you have any questions about the research at any stage, please do not hesitate to contact me or my supervisor:

[redacted] (supervisor).

Yours sincerely,

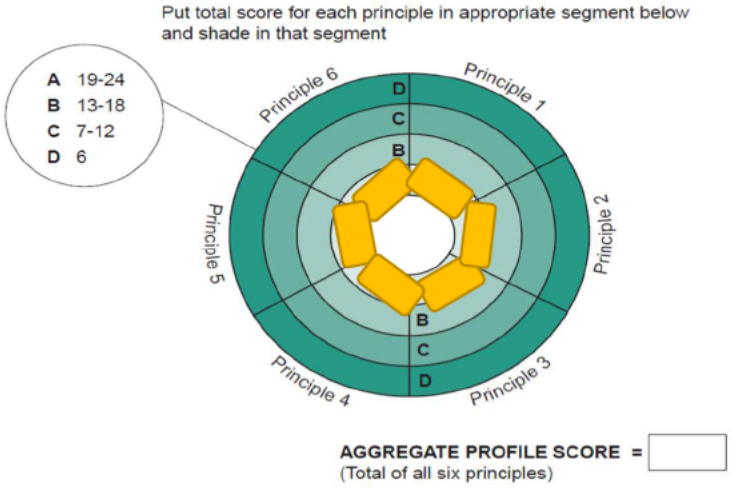
[redacted]

Duncan Alexander PGCARMS MBA BA

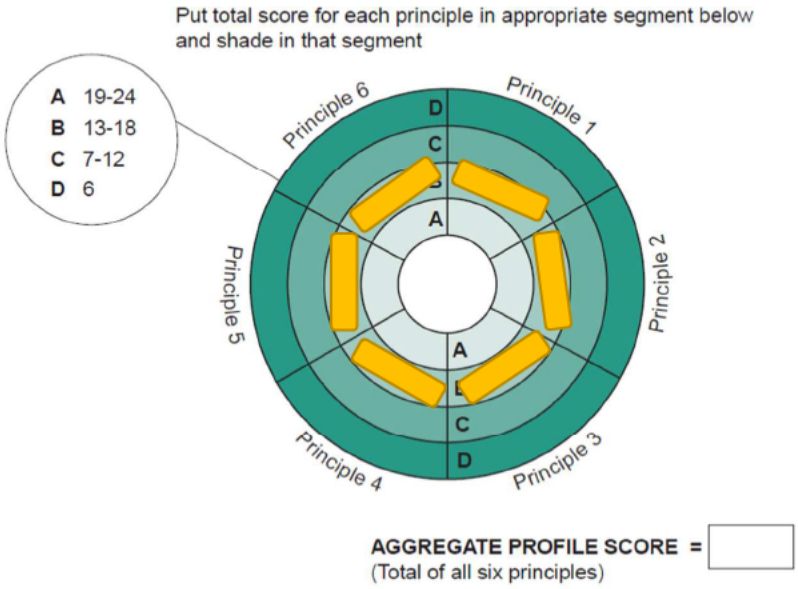
PhD Researcher, University of Birmingham

APPENDIX 4 – DARTBOARD SUMMARY FOR COMPLETED PAT QUESTIONNAIRES

Respondent 1; Snr Mgr Pathology

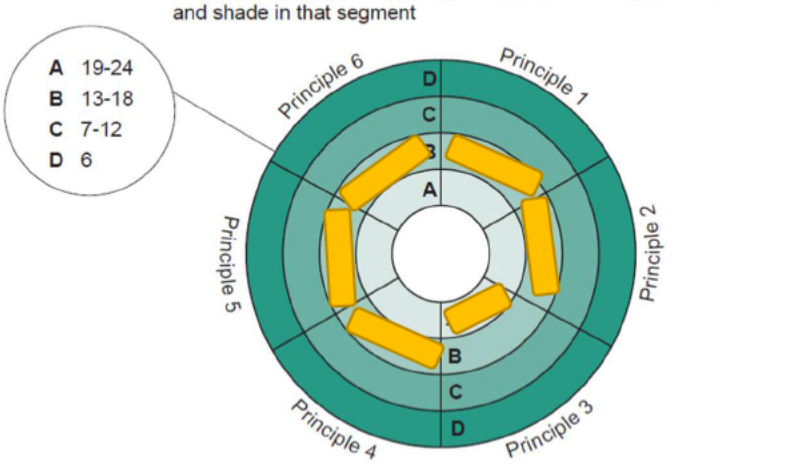


Respondent 2; Mgr NHS Trust 1



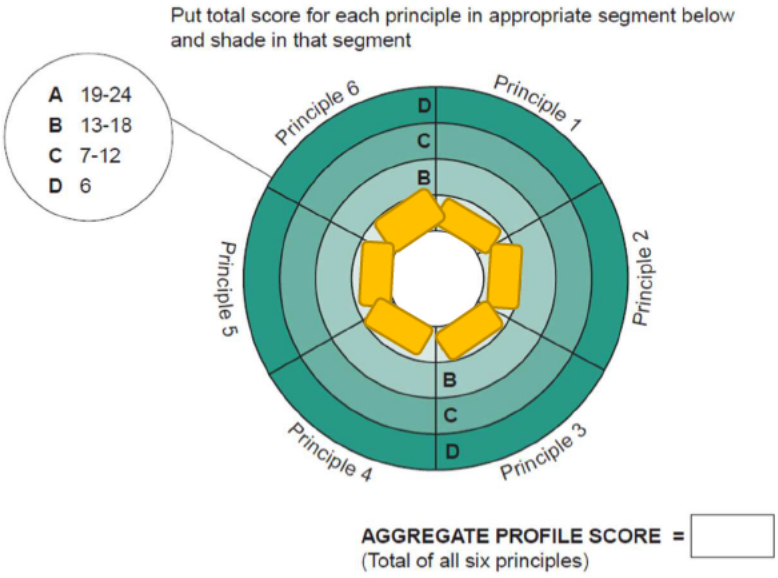
Respondent 3; Mgr NHS Trust 2

Put total score for each principle in appropriate segment below and shade in that segment

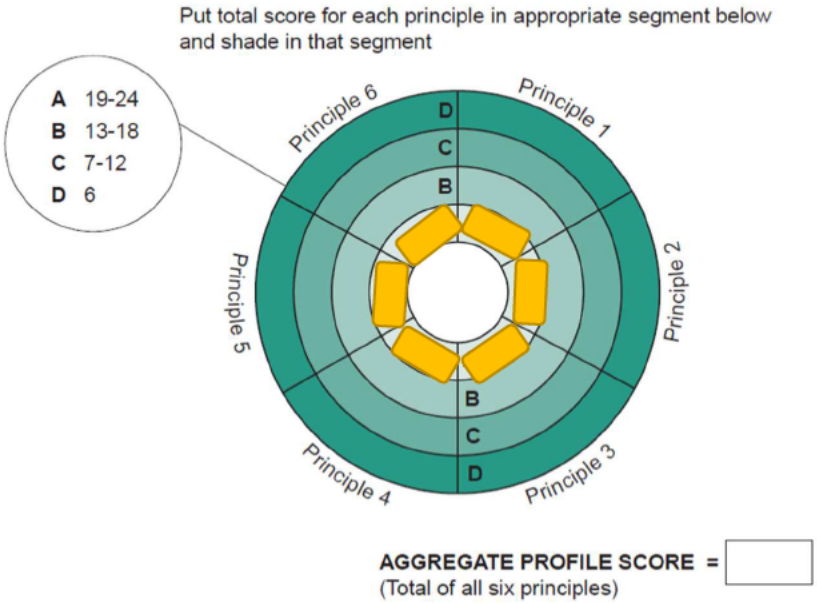


AGGREGATE PROFILE SCORE = ☐
(Total of all six principles)

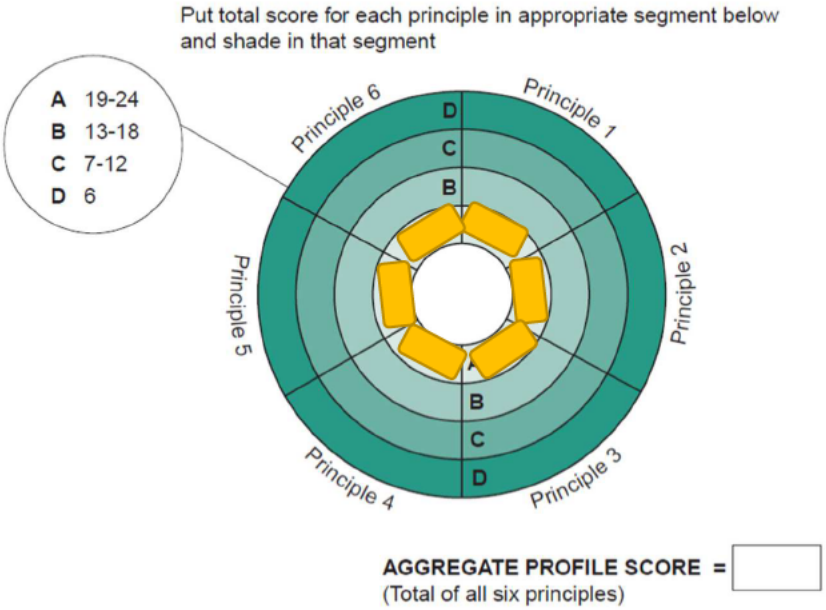
Respondent 4; Snr Mgr IT



NHS Boundary Spanner; Snr Mgr NHS IT Trust



Respondent 5; Snr Mgr NHS Trust WOS



Respondent 6; Snr Mgr WOS