Effective Organisational Forms in the NHS

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Introduction

NHS Leaders are grappling with a range of policy imperatives which have mixed ideology (competition drives up performance; we are all in it together in the Big Society; management gets in the way of clinicians taking responsibility) and which are playing out in a range of what feels like conflicting organisational design features. The NHS itself is moving beyond offering products and services to a more personalised approach of coproducing transformation in people’s lives.

In a context of reduced resources, the need for innovative solutions to changing health needs, and a new relationship between communities, users and professionals, the NHS needs to be able to:

- coproduce services,
- create innovative solutions
- deliver functionality

These three ways of working happen side by side in NHS Trusts and Social Enterprises. The NHS has not as yet come to terms with the multiple organisations forms its needs for the range of work it does. CEOs know that their work is to ensure that services are delivered in a way that is more effective, but there is no one model for all types of service offer, and organisations are working in multiple organisational forms both internally and externally. Moreover they need multiple approaches to membership and partnership based on the issue in front of them.

This paper seeks to describe the ways the NHS organises, how to lead these different forms, how to govern them and what this means for membership; and how to work in partnerships for different types of work.
Choosing Organisational Forms Fit for Purpose

There are primarily three organisational forms for service improvement and delivery. These are:

1. Hierarchies
2. Networks
3. Adaptive Systems

The NHS is most familiar with hierarchies, it’s the dominant model for managing the NHS as a whole, efficient at delivery where it’s very clear what to do, but it’s not often how services are actually delivered, nor is it a useful model for innovation. However there are a multitude of networks in existence and more emerging in the NHS as hierarchies fail to address the need for innovation; and temporary groups forming to solve systemic issues are becoming more common (adaptive systems).

Here we set out the defining characteristics of these three ways of organising, and what it means for members, leaders, and governance.

1. Hierarchies / Beurocracies

In hierarchies what to do is known, evidence-base and deterministic i.e. the consequences of any action are known. Work is allocated through the structure on a need to know and need to do basis. Leadership is positional and appointed for a term. The language in use is of ‘products’, contracts.

Hierarchies are appropriate where the task is to produce replicable, standardized and predictable products and services which can be described in terms of both ‘what’ and ‘how’ in contracts.

Membership implications

Hierarchies have clear leadership and accountability. The role of owners and members is as governors - to set the overall direction and scrutinise, through elected / appointed representatives usually on Boards. The Board gives an account of its performance to its stakeholders who through their elected/ appointed representatives vote on direction, scrutinise performance, hold the accountable officer to account, and ensure the organisation meets regulatory requirements.

As the work in hierarchies is clear, there is little need to engage stakeholders/members in the ‘how’ beyond broad principles that reflect the organisations values (E.g. equal opportunities).

Hierarchies Typically:

- Deliver solutions to tame problems (where you know if you do X then Y will definitely happen)
- Get things done effectively where there is a clear objective and route through to achieving it which isn’t contested.
- Are efficient and effective (with time and resources) when working on linear deterministic problems.
Hierarchies organise through:

- Clear purpose and expectations
- Allocates responsibility for functions (operational, administrative and management)
- Delegates authority to designated levels
- Clarifies discretionary decision making
- Specifies spans of control
- Specifies milestones for delivery
- Performance Management as a process for accountability (not as a process for sense-making) with rewards and punishments
- Power based on expertise and legitimate authority

Hierarchies are useful when

The goal is clear, the course of action to reach that goal is uncontested, there is no need for negotiation, you have the authority and span of control to realise that goal.

Key features of effective hierarchies are:

- They only work on problems amenable to hierarchical control
- There is clarity of purpose, rules of engagement, expected performance, metrics, accountability, sanctions and rewards.

The Leadership behaviour in hierarchies

The leader’s role is to set the direction, the expected behaviours, and the rules for doing business; describe the behaviours expected, and to exercise positional power (power over).

Governance in hierarchies

Within hierarchies delegated authority gives an account to the senior authority, usually in the form of a report, which is subject to scrutiny and judgement. Hierarchies are themselves governed thorough regulation.
2. Networks

Networks often fill the gaps that can’t be addressed by conventional structures. Networks are cooperative structures where an interconnected group or system, coalesce around shared purpose and where members act as peers on the basis of reciprocity and exchange (based on trust, respect, mutuality). Networks form and reform continually in a dynamic way. Leadership emerges from different parts of the network for different work, and leadership of the whole is usually temporary. Networks are creative, innovative places where resources are shared for the ‘common good’. Networks vary in terms of their permanence from adhoc and temporary through to sustainable and legitimate.

As a means of organisation, networks are relatively poorly understood in the NHS, with multiple types of networks emerging across the healthcare landscape.

The distinctiveness of networks lies in:

- Their ability to be innovative and creative and their reliance on diversity
- The distribution of power and leadership across members
- Reciprocity and exchange as the defining relationship between members based on mutual interest around a common purpose.
- Fluctuations in their member engagement and impact
- Their adaptability to survive and thrive
- The centrality of the knowledge function

Networks need to be managed but in collaborative, non-hierarchical ways and the time taken to do this can be underestimated. Networks are high creativity, high maintenance forms.

Membership

Members are the lifeblood of networks, through exchange they contribute resources (ideas, connections, materials, money) to the other members as peers. Members are galvanised by mutual interest and common purpose and member preferences determine the work of the network. Where there is a designated network leader, members lead task groups, learning groups with leadership emerging from the network based on interest and commitment.

There are variations in network types and form (see below) with membership more fluid in some types and more formalised in others, however the basic premise of equality, exchange as a source of innovation are common and the

Networks work

Networks are primarily innovative, creative places. They are useful for rapid learning and development, and amplifying members’ effectiveness. Networks can also be useful for advocacy on behalf of their
membership; for delivering services in ways that makes the most of network members’ capability and resources. Networks:

- **Amplify the work of individual members** – helping and supporting members to learn how to do their work event better than they do it now
- **Generate greater visibility** for work the members within the overall network’s purpose and add reputation to members
- **Generate new knowledge** which will help all network members in their own places
- **Are creative and innovative**
- **Shape the context** (policy level, donor level) in which the network’s work takes place in service to the network’s purpose
- **Deliver services/ outputs** to others as a ‘network offer’ and can deliver services/ resources between members as a ‘support’ offer (e.g. back-office roles) where there are economies of scale.

Note social networks do not typically have all these features – they are intelligence gathering and focus on amplification, visibility, new knowledge only.

**Networks organise through:**

- Clarifying shared purpose (what can we only do together that we can’t do on our own)
- Equal peer relationships based on generosity and reciprocity (of time, skills, information, resources) – everyone must have something to offer
- Requests and offers (not necessarily on the same issue)
- Actively seeking diversity
- Clear rules of engagement (membership)
- Peer working and review
- Member resourcefulness and mutual trust
- Trying things out iteratively

**Networks are useful for:**

- Generating creative and innovative solutions
- Rapid learning and development
- Amplifying the effectiveness of individual members
Key Features of Effective Networks¹

Effective networks have the following key features:

**Shared purpose and identity:** members of effective networks display strong network awareness. They feel ownership and they know why the network exists. They are clear on shared purpose. Members also share a common language and collective narrative.

**Address big issues/ has a compelling purpose:** effective work-based networks that sustain themselves normally address big/ compelling issues that are a high priority for key ‘sponsors’ or stakeholders/members. They are focussed on issues that keep network leaders awake at night and therefore (in some way or another) are likely to receive support.

**Meet member needs:** while effective networks generally address big issues, they also have to be of day to day benefit to members in the network. They ultimately have to link back to either helping members to do their job or helping them to create a change they are passionate about.

**Adapted leadership:** leadership of networks is different to other forms of leadership. Power does not come from organisational hierarchy. Effective networks benefit from leaders that have well developed skills and aptitudes that have the time to perform their role.

**Strong relationships and ties:** effective networks are characterised by strong personal relationships, high levels of trust and awareness between members. Leaders can play a key role in developing trust and a culture of sharing, with face to face events a key aspect in maintaining relationships and ties.

**Generate helpful outputs:** as well as ‘connecting people’, effective networks tend to generate outputs that are helpful to other network members. Outputs are often developed or co-created based on experience ‘on the ground’.

**Networks fail because** of one or more of the following:
- Fails to reach common understanding across members of purpose and direction
- institutionalisation,
- over-management cementing relationships and structures that need to be dynamic and evolving,
- mistakes in initial design or ongoing management,
- over expectation of network member’s willingness or ability to collaborate which damages creativity of the parts;
- predicating network some members over others,
- constraining network member’s independence,
- not recognising when leadership needs to change / rotate
- lack of impact in terms of network member’s purpose.

The leadership behaviour in networks:
Leadership of networks is different from leadership of hierarchies or systems. Networks organise through cooperation and peer based relationships. Network leadership is facilitative, distributed, democratic and inclusive, whilst making the most of difference for creative ends. Network leaders need to focus persistently on membership and impact.

For networks the leadership required to establish a network is often different from the leadership to sustain a network. Leaders connect members, and leaders emerge within the networks based on the task/issue. Leadership is more fluid – it passes from person to person dependent on what’s needed over time.

Governance in networks
As peers network members govern their peers (self-governance) and their own behaviour in relation to
(a) The impact of the network
(b) Members joining in with the basic network rules of equality and reciprocity.

Network Types
Networks exist on a continuum from the ad-hoc to more established endeavours for protracted sustainability and encompass: ‘coalition, partnership, alliance, union, league, association, federation (s) and confederation[s]’

There are a number of distinctive types of networks
- Managed Networks e.g. Diabetes Research Network
- Developmental Networks e.g. Clinical Networks
- Social Networks – social and social movements e.g. Occupy
- Agency Networks – and policy networks e.g. NAAPs/ Shared Lives.
- Learning Networks – enclave, support, communities of practice e.g DispoV Leeds (enclave); AQuA (support)
- Advocacy Networks e.g. Parkinson’s Action Network

Many networks in the NHS are hybrids of these ‘pure’ network types, however their structures and ways of operating do need to reflect the types they embody in order to be effective in their impact. See Appendix one for more detail on each network type.
3. Adaptive Systems

There are intractable ‘wicked’ issues that transcend organisational boundaries, and where no one organisation is either ‘in charge’ and where no one organisation can fix the issue. These are complex system issues that need adaptive collective responses from all parties involved. The one thing all parties can agree on is their shared intent to do better. In these systems every thing you do has intended and unintended consequences and the only way of working is to agree together some steps to take, try those steps, see what impact they have and try some more.

An example of a wicked issue is ‘How can we reduce teenage pregnancy’ the answer lies within social services, parents, schools, teenagers, health services, pharmacists and pharmaceutical companies. All of these form the ‘system’ for that question. The boundaries of the system are determined by the question. So it would be ‘How can we reduce teenage pregnancy in Leeds’ in which case you can describe the agents related to that place/locality/community. The language used in adaptive systems work is about transforming lives.

Adaptive systems are temporary ways of organising. Every party comes to the table with their own perspective, and with a commitment to work in a way that benefits the whole system.

Membership issues

As these are temporary organisational forms, leadership comes from any place in the system, and every person engaged has an equal voice. Every person engaged is a member, owner and participant.

Complex Adaptive Systems:

- Generate order emerges spontaneously
- Have intended and unintended consequences and these can be at quite a distance from the ‘action’ within the system
- Have the answer to the complex problem within the system

Adaptive systems organise through

- Clarifying collective purpose
- Generating guiding principles to shape behaviour within the system
- Building relationships in order to make the most of each other’s potential
- Getting clear together what is actually going on here and now
- Generating visibility for the knock-on effects of any action in part of the system
- Surfacing and working with diverse/different perspectives – the system looks different depending on where you are in it.
- Feedback loops – agreeing what ‘better’ looks like and metrics to enable the whole to make sense of the action it takes
• Sense-making – taking time to review what’s working/ not working and why. This includes challenging assumptions held in parts of the system.
• Connecting the system to itself through multiple conversations and stories.
• Trying things out – just taking some steps, and collectively working out what happened, and doing this iteratively.
• Being future focused

Complex Adaptive Systems are useful for:
Highly contestable problems where it not clear ‘what works’ and where there are multiple interdependent agencies involved in the problem/issue.

Key features of effective complex adaptive systems:
• Persistently clarifying and refining purpose together and using this to determine collective guiding principles
• Have open information and multiple opportunities for sense-making
• Make the most of difference to reach new possibilities through dialogue
• Generate resource capacity to adapt
• Learn together using knowledge (tacit and measurement) of the systems current behaviour
• Are bound together by purpose and identity
• All agents are in it for the long-term

The Leadership behaviour in complex adaptive systems
Keep sighted on the whole, creating the conditions that keep agents/players connected too and responsible for the whole of the system not just their part in it. Leaders provide the architecture (the mechanisms for generating feedback, the place for collective dialogue) and hold the boundaries of behaviour in the system (questioning agents assumptions, keeping focused on purpose).

Governance in complex adaptive systems
Governance is distributed and contested within the whole of the system. Accountability is by the many to the many. Every agent can be called to account for their behaviour by any others within the framework of trying to take the next iterative step together.
What this Means for Membership (in health organisations)

NHS services are now provided by a range of organisations. Some are seeking a more federated model with the Trust or Social Enterprise acting as an umbrella for services provided through a range of organisations. For these emerging organisations the question is

Who owns their services?

For corporates it’s straightforward, their shareholders own the business. Business decisions are to the benefit of shareholders, who in turn have duties in ensuring the business is compliant with for instance employment law; health and safety legislation etc.

But ownership is more complex for public services. It includes:

- those who pay – the tax payers
- their representatives - the national government in the case of the NHS
- those involved in local organisational governance
- those who use services
- and those who work within it.

The notion of ownership implies control – the right to take decisions; and return – the right to ‘have something’ as the owner (access, dividends etc).

For these new public service organisations, whilst some are provided through corporate models, the preference is to develop shared ownership models, where the ownership is based on membership not shareholding. The members (citizens, employees, managers) receive benefits not profits.

There are three major types of shared ownership models

1. The co-operative (see appendix 2 for some examples)
2. The Employee Owned enterprise
3. Limited shared governance

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Cooperatives
Cooperatives around the world have agreed on some basic principles they use to define themselves:

- **Voluntary** (no exclusion from membership on the basis of gender, race political religious or other discriminatory categories)
- **Democratic** – controlled by its members
- **Participatory** – members control the capital of their co-op
- **Autonomous** Agreements with other organisations ensure democratic control is retained
- **Educational** so that members can participate effectively and inform other members of the public
- **Co-operate** with other co-operatives where ever possible
- **Concerned** for sustainable development

(International Co-operative Alliance (ICA) 1995 [www.ica.coop](http://www.ica.coop))

Employee Owned enterprise
Some models of ownership exist in smaller enterprises and craft industries such as Barristers Chambers, Private Medical Consulting Practices.Rooms. Within the NHS, Dental Surgeries are the purest form of Employee Owned Enterprise.

A variation is where a very small minority of the employees become the owners (management buy outs). The evidence shows that these are inherently unstable forms of organisation, leading to either windfalls for the new owners as they sell on; or asset stripping as any capital is used to offset debts in the service.

Limited Shared Governance
There are other examples where employees do not have full ownership rights (i.e. not shareholders) but do have rights to influence policy decisions. The John Lewis Partnership is the best known example in this country. Its employees are called partners. These retail outlets were among the last to move to Sunday opening, a freedom valued by shoppers but unpopular with shop staff.

Federated models
Whilst this model of shared ownership shapes the way owners contribute to and benefit from the organization, this doesn’t answer the issue of innovation to secure better local services. The federated model of organizing, ensures that smaller (localised/personalized/innovative) business units can thrive within an overarching organizational framework often providing core business services, but most importantly ensuring economies of scale with innovation. These are more akin to networked models, where the ‘members’ are the federated
business units, and the model of organizing (making decisions) takes on the rules of networks (each ‘member’ has an equal say; working based on reciprocity etc).

The Future
The future for health sector large social enterprises and Foundation Trusts could be one where they generate

a) a democratic model of shared ownership, and
b) a federated model of business units working as a network

This means decisions are taken

(a) By and with owners
(b) Across the multiple business units together
## Appendix 1: Types of Networks

<table>
<thead>
<tr>
<th>Type of Network</th>
<th>Managed Networks</th>
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</thead>
<tbody>
<tr>
<td><strong>What this network is useful for</strong></td>
<td>Useful where controlled forms of integration of a strongly articulated set of services are required. Enables lucidity and complex work to be broken down across different organisations. Coordination; brokerage; Shared standards; improving practice of the parts.</td>
</tr>
<tr>
<td><strong>How members participate</strong></td>
<td>Frequent meetings but with modest output</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>Hierarchical, less inclusive than other network types, advocacy style of leadership, with clear tasks and budgets suits the managed hierarchical model. Working below the core hierarchy is in peer task groups.</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>Unambiguous, clearly defined authority to regulate members (but strength of hierarchy is variable); Relatively straightforward to performance manage A ‘professional’ model</td>
</tr>
<tr>
<td><strong>Why they work when they do</strong></td>
<td>Mandated network which works when mutually agreed objectives and priorities are shared which connect directly with that of other agents. Retains significant legitimacy with many clinicians.</td>
</tr>
<tr>
<td><strong>Why they fail</strong></td>
<td>If it struggles to achieve support (commitment) from the networks members.</td>
</tr>
<tr>
<td></td>
<td>If it hampers professional member’s autonomy to practice.</td>
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<tr>
<td></td>
<td>When there are problems reaching objective agreement.</td>
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<tr>
<td></td>
<td>When there are sub optimal outcomes; Over-regulation; meagre productivity; inability to create sufficient capital; high transaction costs; congestion via bureaucratic procedures; static designated rules and roles; low (front-line service provider) morale; gateway barriers to higher authority.</td>
</tr>
<tr>
<td><strong>What it takes to run these types of networks</strong></td>
<td>Over-regulation may result in extreme bureaucracy (paper mountains)</td>
</tr>
<tr>
<td></td>
<td>Huge effort/High Resource (transaction costs)</td>
</tr>
<tr>
<td>Type of Network</td>
<td>Developmental / Hybrid</td>
</tr>
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<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>What this network is useful for</td>
<td>Effective at focusing expert minds on activities that have a wider benefit to the system. Amalgamating inspirational leadership and motivational power of healthcare professionals with the task focus of co-ordinating networks</td>
</tr>
<tr>
<td>How members participate</td>
<td>By focusing on specific tasks (improving healthcare access or standards of care for specific patient groups) where the members can learn and change.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Boundary spanner (intermediary leaders)</td>
</tr>
<tr>
<td>Governance</td>
<td>Financial and Clinical accountability is the responsibility of participant members and remains separate</td>
</tr>
<tr>
<td>Why they work when they do</td>
<td>Used to develop hub and spoke models of care. Innovative, flexible and adaptable to changing healthcare contexts based on principles of effective partnership working.</td>
</tr>
<tr>
<td>Why they fail</td>
<td>Limited success in solving the problems of capacity and fragmentation. Complex decision making process for implementing new structures and innovation-based services. Tensions between interests and priorities When they don’t make agreements between members that are binding.</td>
</tr>
<tr>
<td>What it takes to run these types of networks</td>
<td>Nascent solutions/ need to be properly developed.</td>
</tr>
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## Developmental Networks

<table>
<thead>
<tr>
<th>Type of Network</th>
<th>Clinical</th>
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</table>
| What this network is useful for | Bringing hybrid healthcare services to a population across wide geographical area.  
Strategic use of scarce resources (money, technology and expertise) for greater impact. |
| How members participate | Connection of organisations to provide evidence based healthcare services, operating across different levels. |
| Leadership | Context dependant – leadership rotates dependent on need  
Entrepreneurial or Transformational leadership style (can include small team based leadership);  
Leader open to grassroots engagement (context dependent) |
| Governance | Robust arrangements needed for different types of clinical nets. |
| Why they work when they do | Work well when all parties engage including clinicians, other healthcare professionals and patients/users/carers etc. converge around a pathway.  
Work well when supported by an evidence base |
| Why they fail | Need to negate risk of little dictators or monopolies or perhaps conflict of interest. |
| What it takes to run these types of networks | Professional credibility; adaptive leadership; rotational leadership. |
## Social Networks

<table>
<thead>
<tr>
<th>Type of Network</th>
<th>Social Networks &amp; Social Movements</th>
</tr>
</thead>
</table>
| **What this network is useful for** | Instigating policy change.  
Campaigning.  
Intelligence gathering.  
Building reputation.  
Visibility.  
Learning. |
| **How members participate** | Communication via social mediums.  
Fluid, dynamic interaction (London riots via Blackberry Messenger/ networks one step ahead of system).  
No one course of action - try, try, try again; |
| **Leadership** | No one leader.  
May have various formal/informal leaders |
| **Governance** | Good when seeking fewer structural solutions.  
Little authority to regulate members; self-organising; members regulate through peer pressure.  
Hard to performance manage |
| **Why they work when they do** | New ideas and ways of doing things may not commence immediately, but spread via social nets.  
Rapid access to latest intelligence.  
Social movements can be created within short space of time so are very responsive |
| **Why they fail** | Social capital not always a public good.  
Institutionalisation and becomes mainstream |
Part of the problem
Government and societies’ incapability of perceiving groups as self-organised networks

What it takes to run these types of networks
High level of social media, and energy from network member

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<tr>
<th>Agency Networks</th>
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<tbody>
<tr>
<td><strong>Type of Network</strong></td>
</tr>
<tr>
<td><strong>What this network is useful for</strong></td>
</tr>
<tr>
<td><strong>How members participate</strong></td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
</tr>
<tr>
<td><strong>Governance</strong></td>
</tr>
<tr>
<td><strong>Why they work when they do</strong></td>
</tr>
<tr>
<td><strong>Why they fail</strong></td>
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<tr>
<td><strong>What it takes to run these types of networks</strong></td>
</tr>
<tr>
<td><strong>Type of Network</strong></td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Enclave / Support / Coalition of Interest</strong></td>
</tr>
<tr>
<td><strong>What this network is useful for</strong></td>
</tr>
<tr>
<td><strong>How members participate</strong></td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
</tr>
<tr>
<td><strong>Governance</strong></td>
</tr>
<tr>
<td><strong>Why they work when they do</strong></td>
</tr>
<tr>
<td><strong>Why they fail</strong></td>
</tr>
</tbody>
</table>
## Learning Networks

### Communities of Practice

<table>
<thead>
<tr>
<th>Type of Network</th>
<th>Learning about identified practice through doing with others.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Role Learning, can also be about delivery or creation of new knowledge (in their most mature form)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How members participate</th>
<th>People embedded in CoP because something needs to be done and they identify with peers wanting to learn about the same. Participate as mutual learners.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Usually participation is facilitated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Requires an ecosystem that instigates net weaving across all levels</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Governance</th>
<th>Professional integrity and inculcation, and arranging for improvisation and experimentation.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Why they work when they do</th>
<th>Members share a passion and commit to frequent interactions.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Where there is commitment to developing expertise, and working together to solve problems</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Why they fail</th>
<th>Community is a contested concept</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Why CoPs fail (Roberts, 2006) Neglects power; doesn’t acknowledge pre-existing social codes;</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What it takes to run these types of networks</th>
<th>Challenging to maintain energy and participation rates with a shifting set of participants.</th>
</tr>
</thead>
</table>

Based values.
Isolation from large stakeholder groups.
Breakdown of trust between agents (people and orgs).

What it takes to run these types of networks
Challenging to maintain energy and participation rates.
<table>
<thead>
<tr>
<th><strong>Type of Network</strong></th>
<th><strong>Advocacy Networks</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What this network is useful for</td>
<td>Advocating for shared common cause</td>
</tr>
<tr>
<td>How members participate</td>
<td>Collection of organisations or individuals with common purpose taking leadership as required, based on need.</td>
</tr>
<tr>
<td></td>
<td>Refinement of core purpose and agreed impact.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Rotational based on issue, availability and need.</td>
</tr>
<tr>
<td>Governance</td>
<td>Self-governing.</td>
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<td></td>
<td>Accountable to members for impact</td>
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<tr>
<td></td>
<td>Democratic</td>
</tr>
<tr>
<td>Why they work when they do</td>
<td>Work when having clear impact and democratic engagement makes the best of all parties.</td>
</tr>
<tr>
<td>Why they fail</td>
<td>Dissolve if members do not achieve the impact they intended.</td>
</tr>
<tr>
<td></td>
<td>Overly concerned for democracy gets in the way of action.</td>
</tr>
<tr>
<td></td>
<td>Too blinkered on their own remit and not connected to wider context.</td>
</tr>
<tr>
<td>What it takes to run these types of networks</td>
<td>Commitment to democratic process and cause.</td>
</tr>
</tbody>
</table>
Appendix 2: Examples of Cooperatives

Co-operatives have received very little attention from politicians and the media but they have continued to thrive and many expect to see a renaissance in the near future (Mayo and Moore 2001). Co-operatives directly employ 100 million people worldwide, 20% more than multinational corporations. Co-operatives represent more than 800 million people worldwide and their membership increased faster than the population growth in every region except Europe (www.ica.coop).

Most co-op members belong to consumer societies in which ownership is based on membership not shares, and members receive ‘profits’ as better prices and services e.g. the phone co-op which competes on price and services in the highly competitive UK telephone market. Credit unions (slightly less than a third of worldwide membership) are set up for people who can’t access credit through the usual financial institutions. Many Agricultural coops (approx one fifth of the total membership) help small producers band together to buy equipment, to market or to distribute their products. 14 million co-op members have a 55% share of total farm products in Europe. There are also a few housing and worker owned cooperatives. Membership here is limited to workers who own equal shares but they may operate within hierarchies of management and rewards (International Labour Organisation www.ilo.org) Magnum, the photographers agency is a longstanding example. Some are controlled by the workers but owned by a Trust (the Guardian newspaper and the CP Scott Trust). Information on co-operatives in the UK is available from www.cooperatives-uk.coop.

The UK Co-operative group has 7 million members, where individual members have a voice through their local area committees, from which a democratic structure of elections builds the governance structure higher up the organisations (Regional Boards and then the Group Board). Reciprocity of time and commitment and investment for entitlement, control and influence underpins their membership model. More involvement brings more reward individually and for the business as a whole.

Where co-operatives have behaved in ways indistinguishable from their corporate counterparts they have fallen into rapid decline. In the 1950s the Co-op in Britain was the largest retailer and agricultural landowner, and the Mutual financial sector of building societies has been largely demutualised.

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