Decentring Networks and Networking in Health and Care Services

Mark Bevir and Justin Waring

The Network Narrative

It is widely proclaimed we now live in a networked society, in which the proliferation of information communication technologies has made possible new and diverse forms of inter-connected social, cultural and economic activity (Castells 2011). Although the network concept is often invoked with reference to new social media and rapidly changing modes of social organisation, it also stems from a long-standing stream of sociological and anthropological thinking about

M. Bevir
Department of Political Science,
University of California, Berkeley, CA, USA
e-mail: mbevir@berkeley.edu

J. Waring (✉)
Health Services Management Centre,
University of Birmingham, Birmingham, UK
e-mail: J.Waring@bham.ac.uk

M. Bevir and J. Waring (eds.), *Decentring Health and Care Networks*, Organizational Behaviour in Healthcare,
https://doi.org/10.1007/978-3-030-40889-3_1

the inter-connected and patterned features of everyday social life, such as kinship, occupational or community networks (Scott 2002). And yet, the network concept simultaneously encourages a distinct level of social science enquiry that attends, less to people or places as categorical units of social organisation, and more to the relationships between them as mediated by different interactions and technologies (Scott 2002).

The network narrative has become a ubiquitous feature of contemporary public policy (Hajer et al. 2003; Kickert et al. 1997). In broad terms, it is widely believed that the social, economic and political challenges facing society today require the diverse resources and capabilities of different specialists and stakeholders to participate in more inclusive policy making and to implement more coordinated solutions. The network narrative tends to follow a familiar logic (Bevir 2013). That is, traditional modes of public administration were dominated by the centralised, top-down authority of the State, with policy decisions implemented through bureaucratic planning and delegation. This supposedly stifled innovation and reinforced siloed working to the detriment of responsive and efficient public services. The neoliberal reforms of the 1980s and beyond saw the introduction of more business-like New Public Management (NPM) whereby a multitude of decentred policy actors became responsible for making and implementing policy decisions, typically on the basis of individual self-interest with market-like relations. This was seen as fragmenting public services to the extent that public service organisations could not collaborate around the complex problems facing society. The network narrative emerged as a response to the limits of both bureaucracy and markets by advocating for a model a public governance in which multiple policy actors share resources, make more joined-up decisions, and provide more coordinated services. For many advocates, New Public Governance (NPG) represents a more progressive, inclusive and democratic approach that is associated with qualities such as trust, mutuality and commitment, collaboration and co-design; rather than contractual obligation or delegated rule.

Within the public policy and management literature, the term 'policy networks' has been defined as '*(more or less) stable patterns of relations*

between independent actors, which take shape around policy problems and/or policy programmes' (Kickert et al. 1997). Advocates put forward a number of potential benefits. First, networks offer more inclusive and democratic decision-making through enabling multiple stakeholders to shape policies and services (Ansell and Gash 2008). Second, networks provide flexibility to help local actors work together to address 'wicked' policy problems whose solution is beyond the scope of a single organisation (Ferlie et al. 2013). Third networks bring together the skills and resources of divergent actors thereby enabling more dynamic and innovative responses to policy problems (Klijn and Koppenjan 2000). Fourth, networks promote open, trusting, reciprocal and cooperative relationships between organisations and individuals (Kickert et al. 1997), leading to more efficient ways of working and promoting knowledge sharing and innovation.

Arguably, the network narrative illustrates the influence of particular social science ideas on public policy and management. Klijn and Koppenjan (2012) describe how three distinct underpinning perspectives inform contemporary thinking on 'network governance'. The first draws from political science, where policy networks are associated with more inclusive and deliberative decision-making (Ansell and Gash 2008). The second stems from the field of economic sociology and later organisational studies where it is shown that inter-organisational networks promote innovation through facilitating resource sharing (Burt 2009; Granovetter 1973). The third, and most relevant here, is found within the field of public policy and management where networks are seen as an alternative model of service organisation and delivery that offers more coordinated and integrated responses to cotemporary policy problems (Ferlie et al. 2013). Through the convergence of these different traditions a, seemingly, dominant policy narrative has emerged.

And yet, in some ways the network narrative is in arguably idealised. It might be suggested, for example, that the idea of epoch-like shifts between bureaucratic public administration, NPM and NPG are over-stated with public governance characterised by more complex, layered or hybrid governance arrangements (Pollitt 2009). Although some have talked of a 'Hollow State' or 'polycentric' public services,

we also know that centralised state regulations continue to influence how local policy actors operate both within markets and networks (Lowndes and Skelcher 1998). It also the case that policy actors are expected to simultaneously compete on some issues, whilst collaborating on others (Bevir and Waring 2017). Further still, changing professional institutions, boundaries and status hierarchies continue to complicate all varieties of public policy and management (Waring and Currie 2009).

In other ways, the network narrative adopted by policy makers has the potential to reify social relationships rendering them as concrete and amenable to planning and management. By this we mean, that networks are often presented as tangible or discrete entities based upon the formation of new working relationships between disconnected groups (Waring et al. 2017). As such, if the network is appropriately designed with the necessary agents, and appropriate directives and incentives are provided, it will result in the sharing of resources and service improvement. This can be seen, for example, with the extensive literature on 'mandated' or 'managed networks' and the corresponding upsurge of interests in 'network management' and 'network orchestration' which speak to the idea that managers need identify and recruit specific network actors, build network relationships and leveraging collective benefits (Klijn et al. 2010; McGuire 2006). And yet, the realities of 'network management' is far from straight forward because of the narrow ways network relations, much like cultures, are seen as amenable to management intervention (McGuire and Agranoff 2011; Waring and Crompton 2019).

Turning to the wider social science literature, 'social networks' might be understood, more broadly, as the relatively stable patterns of interaction common to practically all aspects of social life, which become institutionalised around certain activities or tasks in the form of a community or network (Crossley 2010). Early anthropological interest in social networks is often credited to Barnes (1954) who claimed that "the whole of social life" could be seen as a "set of points some of which are joined by lines" to form a total network of relations (1954: 43). Based on the conception of society as formed through an interconnecting web of relations, social scientist began systematically to denote patterns of

existing relationships seeing social structure as a collection of points (representing individuals, groups or organisations) and various types and strengths of links between them. These networks are not designed, manufactured or created, but emerge overtime through social interaction, and become institutionalised through social conventions and customs, and eventually social rules (Owen-Smith and Powell 2008). These networks provide the social infrastructure through which meanings, values and identities are shared and reinforced; through which actors social position and influence can be understood; and through which social activities are organised. In this sense, networks are not, and cannot easily, be created or managed. (Crossley 2010).

Networks and Networking in Healthcare

It is probably fair to say that the English health and care system has often been at the very forefront of broader transitions and trends in public policy and governance (Ferlie et al. 2013). Its creation in the immediate post-war period, and subsequent reforms in the 1960s and 1970s, very much illustrate the ideals of a centralised state-run public service bureaucracy. Management reforms of the 1980s and market reforms of the 1990s exemplified the rise and maturation of NPM as a template for more responsive, efficient and competitive public service delivery (Strong and Robinson 1990). Similarly, from the late 1990s onwards, the mantra of collaboration, partnerships and networks has come to redefine health policies and service organisation (Ferlie et al. 2013). The network narrative has re-shaped almost all aspects of the health care system from high-level policy decision-making where government departments coordinate activities around policy problems, to regional care planning through networks of health and social care agencies, through to inter-professional networking in frontline service delivery (Waring et al. 2017).

In their review of inter-organisational networks in healthcare, Sheaff and Schofield (2016) distinguish between six different types of networks, including (i) 'care networks' involved in the coordination of care services; (ii) 'professional networks' for the coordination and

representation of occupational interests; (iii) 'project networks' that form around a specific initiative; (iv) 'programme networks' designed to implement a given policy or reform programme; (v) 'experience networks' that bring together patients or publics with shared experiences and interests; and (vi) 'interest networks' that mobilise around particular agendas. This typology reveals how networks in health care can vary according to purpose and intent, form and structure, and interest and ideology. Moreover, it shows how some are seemingly the object of policy or management, in so much that they are a tool or technique of governance; whereas other are more emergent and potential in opposition to policy, in so much that they advance divergent interests.

In the contemporary context, three prominent initiatives give a clear sense of the way the network narrative continues to guide health and care reforms; each of which is the subject of research presented in this collection. The first can be seen with the renewed emphasis on regional strategic networks as a platform for prioritising, planning and delivering a more coordinated care services, as set out in the NHS *Five Year Forward View* (NHS England 2015). The broad goal of policy is to change way multiple health and care agencies work together within a regional footprint in order to optimise the allocation of scarce resources, deliver more integrated services and improve population health. Prominent examples of this can be seen with the introduction of, what have been variously termed, Sustainability and Transformation Plans (later Partnerships), Accountable Care Organisations, and Integrated Care Systems. Other attempts to change 'system architecture' including the recent introduction of Primary Care Networks. In many ways, this particular policy agenda is shaped by the longstanding view that complex care needs require the involvement of multiple specialists working across the health and social care boundaries. At the same time, the promotion of regional networks stems from the necessity of dealing with resource constraints created by austerity measures and the removal of more formal administrative or bureaucratic strata within the NHS following the Health and Social Care Act of 2010, specifically Strategic Health Authorities.

The second example can be seen in the continued re-organisation of services through regional or locality service delivery networks (Fulop et al. 2015). Traditionally, acute and specialist NHS services have been

organised and delivered through local or 'district' hospitals, but typically with limited horizontal integration with other care providers. The shift towards a network model is guided, in part, by mounting research evidence that suggests the distribution of specialist services across multiple care providers often results in sub-standard and variable outcomes, especially where smaller district hospitals have limited expertise in complex cases. It follows, therefore, that concentrating the provision of specialist services within fewer regional centres, and encouraging these services to work in more coordinated or networked ways will result in benefits for workforce development from greater exposure to complex case, increased resource optimisation from reducing unnecessary duplication, and improved patient outcomes from better specialised care. In other ways, this includes creating better links between specialist centres to promote care standards, share 'best practice' and reduce variations. Prominent examples include the introduction regional networks for cancer, stroke, and major trauma care.

The third example addresses the well-document 'translation gap' between the production of evidence-based innovations, on the one hand, and the implementation and adoption of these breakthroughs in everyday care delivery, on the other. It is said, for example, that it can take as much as 15 years for new therapies or technologies to make a routine impact on patient care, and whilst some time is needed to ensure safety and effectiveness, excessive delay represents potentially wasted resources and unnecessary human suffering (Cooksey 2006). For over a decade, policies have sought to address this problem through supporting more collaborative partnerships and networks between research 'producers' and 'users'. This often centres on encouraging NHS care providers to work more collaboratively with university-based researchers and industry in the form of research networks (Kislov et al. 2018). Prominent examples include Academic Health Science Networks (AHNS), Collaborations for Leadership in Applied Health Research and Care (CLARHCs), Applied Research Collaborations (ARCs), and other disease-specific research networks. Of relevance to the decentred approached developed in this collection, the formation of these networks is often shaped by the local traditions of university-healthcare collaboration (Rycroft-Malone et al. 2013), as well as the dilemmas of

regional geo-politics between competing university and NHS partners (Waring et al. 2020).

These three prominent examples show how networks, or more precisely the network narrative, continues to shape the modernisation and transformation of health and care services. The chapters in this collection examine directly the manifestation of networks and networking in these and other areas of health and care reform. Unlike the much of the existing research on networks, this collection seeks to a develop a more enquiring, critical and decentred understanding of networks as an idealised or prescriptive model of health care governance.

Decentred Theory

Modernist social science typically seeks mid-level or general theories by which to explain the particulars of social life, including the adoption, operation, and effects of a policy. They prefer formal and abstract explanations, as opposed to historical or context-specific, precisely because they conceive that explanations must be synchronic accounts that persist across multiple cases from which to build a mid-level or general theory (Brady and David 2004; King et al. 1994). Decentred theory contrasts sharply with this modernist approach. Decentred theory is overtly historicist in its emphasis on agency, contingency, and context (Bevir 2003a; Bevir 2013). It rejects the hubris of mid-level or comprehensive explanations that claim to unpack the essential properties and underlying logics of social and political life. So, for example, it suggests that neither the intrinsic rationality of markets, nor the path dependency of institutions, properly determines whether policies are adopted, how they coalesce into patterns of governance, or what effects they have. Rather, decentred theory conceives of public policies as contingent constructions of actors, inspired by competing beliefs that are rooted in different traditions and which evolve in the face of changing situations or dilemmas. That is, decentred theory examines the ways in which patterns of rule, including both institutions and policies, are created, sustained, and modified by individuals through their meaningful social practices that arise from the beliefs individuals adopt against

the background of traditions and in response to dilemmas. It suggests that policies arise as conflicting beliefs, competing traditions, and varied dilemmas generate, sustain, and transform diverse practices. It focuses attention on the diverse ways in which situated agents make and remake policies as contested practices. Decentred theory therefore suggests that social scientists focus on a particular set of empirical topics, in this case health care networks as an example of contemporary governance.

Too many social scientists adopt forms of explanation that reduce actors' beliefs to formal axioms of rationality or to synchronic patterns associated with institutions, systems, or other social facts. Decentred theory begins instead with the idea that actions should be explained with reference to the reasons and meanings that actors have for those actions. Crucially, decentred theory suggests, first, that social scientists explain these reasons by locating them in the agents' *webs of belief*, and second, that social scientists explain these webs of belief by locating them in a historical context of traditions and dilemmas. If we reject positivism, and the idea of understanding human behaviour by reference to objective social facts, we must explore the beliefs and meanings through which actors themselves construct their world, including the ways they understand all their position, the norms affecting them, and their interests. Because people cannot have pure experiences, their beliefs are inextricably enmeshed with theories and traditions.

Two sets of concepts therefore provide the basis for thinking about the meaningful actions of actors. The first set includes concepts such as tradition, structure, and paradigm (Bevir 2013; Kuhn 2012: 43–51). These concepts explore the social context in which individuals think and act. They vary in how much weight they suggest should be given to the social context in explanations of thought and action. We define a 'tradition' as a set of understandings an actor receives during socialization. Although tradition is unavoidable, it is only ever a starting point, not something that governs later performances. We should be cautious, therefore, of representing tradition as an unavoidable presence in everything people do as this risks leaving too slight a role for agency. In particular, we should not imply that tradition is constitutive of the beliefs people later come to hold or the actions they then perform. Instead, we should see tradition mainly as a backdrop or underlying

influence on people. Just because individuals start out from an inherited tradition does not imply that they cannot adjust it. On the contrary, the ability to develop traditions is an essential part of people's being in the world. People constantly confront, at least slightly, novel circumstances that require them to apply inherited traditions anew, and a tradition cannot fix the nature of its application. When people confront the unfamiliar, they have to extend or change their heritage to encompass it, and as they do so, they develop that heritage. Every time they try to apply a tradition, they reflect on it, whether consciously or not, to bring it to bear on their circumstances, and by reflecting on it, they open it to innovation. Thus, human agency can produce change even when people think they are sticking fast to a tradition they regard as sacrosanct.

The second set includes concepts such as dilemma, anomaly, and agency (Bevir 2003b; Kuhn 2012: 52–65). The concept of 'dilemma' provides one way of thinking about the role of individual agency in changing such traditions. People's capacity for agency implies that change originates in the responses or decisions of individuals. Whenever someone adopts a new belief and associated action, they have to adjust their existing beliefs and practices to make way for the newcomer. To accept a new belief is thus to pose a dilemma that asks questions of one's existing beliefs. A dilemma arises for an individual or institution when a new idea stands in opposition to existing beliefs or practices and so forces a reconsideration of these existing beliefs and associated tradition. Traditions change as individuals make a series of variations to them in response to any number of specific dilemmas. A related point to make is that dilemmas do not have given, nor correct, solutions. Because no set of beliefs can fix its own criteria of application, when people adopt new ideas they change traditions creatively. It might look as if a tradition can tell people how to act; how to respond to dilemmas. At most, however, the tradition provides a guide to what they might do. It does not provide rules fixing what they must do.

It is important to recognize that social scientists cannot straightforwardly identify dilemmas with allegedly objective pressures in the world. People vary their beliefs or actions in response to new ideas or perceived situations. They do so irrespective of whether that new idea reflects real pressures, or, to be precise, irrespective of whether it

corresponds to a pressure perceived real by social scientists. In explaining change, there is no reason to privilege academic accounts of the world. What matters is the subjective and intersubjective understandings of local actors, not scholarly accounts of real pressures in the world. The task of the social scientist is to recover the shared intersubjective dilemmas of the relevant actors.

A decentred approach highlights contests among diverse and contingent meanings rooted in different traditions and the dilemmas faced by actors in particular contexts. As a result, it privileges specific new empirical topics with a particular focus on the context-specific practices enacted by actors and the meanings that inform them. In looking at the interplay between traditional, dilemma and meanings in action, a decentred approach focuses on narratives, rationalities, and resistance (Bevir 2010). 'Narratives' convey complex sets of meanings, rooted in historical circumstances, and providing a shared framework for meaning making and social practices. Narratives assist actors in sense-making and confronting novel situations and dilemmas, and in turn narratives are made and re-made through social practice. Narratives are inherently political or ideological, conveying not only meanings, but also moral imperatives. A decentred theory suggests that social scientists should pay more attention to the traditions against which elites construct their worldviews, including their views of their own interests. Moreover, the central elite need not be a uniform group, all the members of which see their interests in the same way, share a common culture, or speak a shared discourse. Our decentred approach suggests that social scientists should ask whether different sections of the elite draw on different traditions to construct different narratives about the world, their place within it, and their interests and values.

Relating these ideas to the study of networks and networking in healthcare, it encourages analysis to move beyond the reified notion of networks as technical instruments of top-down government within which different actors and agencies see their worlds reconfigured, Rather we need to see networks as sites of multiple, shared and contested meaning, where diverse actors engage in network-related activities based upon their prevailing traditions or systems of belief. This means that the practices of networking for one group can be radically different

from another, and from the prescribed vision of policy or social science theory. Furthermore, the introduction or imposition of networks as a policy instrument might be seen as creating the types of disruptions and changes that create the dilemmas for social actors. In these situations, actors and groups of actors draw upon their prevailing meanings, such as what networking means to them, and at the same time develop new meanings in the face of contradictions. Through enacting traditions and dealing with dilemmas, actors create the social reality of networks and networking that can depart from and resist the narratives of policy-makers. In short, networks and networking is made real through the situated and meaningful practices of health and care actors as they enact or resist a networked model of care.

The Contributions to This Collection

In different ways, the chapters in this collection develop a critical and decentred analysis of the ways networks and networking have re-shaped, or at least tried to re-shape, the organisation and governance of health and care services. They each focus on a particular examples of networking in contemporary health and care reform, such as integrated health and social care models (Bishop), research collaborations (Ledger, Vickers), inter-organisational mergers and buddying (Millar), regional stroke networks (Baeza), and networks for stakeholder or patient involvement (Williams); as well as focusing on different dynamics of networking, such as the role of technology-mediated networks (Pope), the role of stories and storying-telling (Turner), and the motivation of actors to engage in networking (Hyde). In different ways, they show how policy narratives often present an idealised or reified understanding of networks that downplays both the underlying ideology or rationality of policy, and neglects the ways networks and networking is enacted through the situated and meaningful practices of actors; and how the situated practices of networking often divergent from or resist the intent or assumptions of policy.

Furthermore, the collection offers extensions to the application of decentres theory in the study of health and public policies. Given their

focus on networks and networking, it is perhaps unsurprising that many chapters bring to light the inter-active and relational dynamics of networks, especially the idea of inter-subjective meaning located in shared webs of belief (Bishop, Hyde, Turner), but also the potential for new relationships to form around dilemmas (Baeza, Hyde, Millar). The chapter also show how dilemmas might not simply arise in the context of new or changing circumstances, but how they can be cultivated and used to advance certain agendas (Baeza, Bishop). In other ways, the chapters give closer attention the spatial, affective, and motivational dimensions of traditions and meaningful action (Bishop, Hyde, Vickers). That is, meaningful action is always located in a space to which different traditions ascribe meaning, and where new policies seek to create new meanings around which dilemmas emerge (Bishop). They also show how the emotional consequences of networking can shape how actors make sense of and seek to act in the context of reforms (Turner), especially in terms of how this shapes the motivations and intents of actors (Hyde). More broadly, the chapters reveal how juxtaposition between local traditions of networking and policy narratives for networking can create dilemmas but also opportunities for resistance or creative mediation of interests (Ledger, Turner, Vickers).

In other ways, the chapters draw on additional theoretical perspectives to enrich or critique the decentred approach. This includes, for example, concepts and ideas derived from Actor Network Theory to understand how intended or expected modes of organising work become thwarted and resisted in the everyday practices human and non-human networks (Pope). Theories of inter-subjective storytelling and meaning making complement the decentred interest in narratives to rethink the processes of learning and innovation in the context of dilemma (Turner). In addition, the ideas of Foucault are invoked to thinking about the relational dynamics of power and governance in healthcare networks, especially the role of pastoral power in the implementation of evidence-based care (McGivern). And as outlined above, theories of space and place also offer additional ways of thinking about tradition and dilemma (Bishop).

References

Ansell, C., & Gash, A. (2008). Collaborative governance in theory and practice. *Journal of Public Administration Research and Theory, 18*(4), 543–571.

Barnes, J. A. (1954). Class and committees in a Norwegian Island Parish. *Human Relations, 7*(1), 39–58.

Bevir, M. (2003a). A decentred theory of governance. In H. Bang (Ed.), *Governance as social and political communication*. Manchester: Manchester University Press.

Bevir, M. (2003b). Notes toward an analysis of conceptual change. *Social Epistemology, 17,* 55–63.

Bevir, M. (2010). Interpreting territory and power. *Government and Opposition, 45,* 436–456.

Bevir, M. (2013). *A theory of governance*. Berkeley: University of California Press.

Bevir, M., & Waring, J. (Eds.). (2017). *Decentring health policy: Learning from British experiences in healthcare governance*. London: Routledge.

Brady, H., & David, C. (Eds.). (2004). *Rethinking social inquiry: Diverse tools, shared standards*. Lanham, MD: Rowman & Littlefield.

Burt, R. S. (2009). *Structural holes: The social structure of competition*. Cambridge: Harvard University Press.

Castells, M. (2011). *The rise of the network society* (Vol. 12). West Sussex: Wiley.

Cooksey, D. (2006). *A review of UK health research funding*. London: The Stationery Office.

Crossley, N. (2010). Networks and complexity: Directions for interactionist research? *Symbolic Interaction, 33*(3), 341–363.

Ferlie, E., Fitzgerald, L., McGivern, G., Dopson, S., & Bennett, C. (2013). *Making wicked problems governable? The case of managed networks in health care*. Oxford: Oxford University Press.

Fulop, N. J., Ramsay, A., Perry, C., Boaden, R., McKevitt, C., Rudd, A., et al. (2015). Explaining outcomes in major system change: A qualitative study of implementing centralised acute stroke services in two large metropolitan regions in England. *Implementation Science, 11*(1), 80.

Granovetter, M. S. (1973). The strength of weak Ties1. *American Journal of Sociology, 78*(6), 1360–1380.

Hajer, M., Hajer, M. A., Wagenaar, H., Goodin, R. E., & Barry, B. (Eds.). (2003). *Deliberative policy analysis: Understanding governance in the network society*. Cambridge: Cambridge University Press.

Kickert, W. J., Klijn, E. H., & Koppenjan, J. F. (Eds.). (1997). *Managing complex networks: Strategies for the public sector*. London: Sage.

King, G., Robert, O. K., & Sidney, V. (1994). *Designing social inquiry: Scientific inference in qualitative research.* Princeton, NJ: Princeton University Press.

Kislov, R., Wilson, P. M., Knowles, S., & Boaden, R. (2018). Learning from the emergence of NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs): A systematic review of evaluations. *Implementation Science, 13*(1), 111.

Klijn, E. H., & Koppenjan, J. F. (2000). Public management and policy networks: Foundations of a network approach to governance. *Public Management an International Journal of Research and Theory, 2*(2), 135–158.

Klijn, E. H., & Koppenjan, J. (2012). Governance network theory: Past, present and future. *Policy & Politics, 40*(4), 587–606.

Klijn, E. H., Steijn, B., & Edelenbos, J. (2010). The impact of network management on outcomes in governance networks. *Public Administration, 88*(4), 1063–1082.

Kuhn, T. (2012/1962). *The structure of scientific revolutions*. Chicago: University of Chicago Press.

Lowndes, V., & Skelcher, C. (1998). The dynamics of multi-organizational partnerships: An analysis of changing modes of governance. *Public Administration, 76*(2), 313–333.

McGuire, M. (2006). Collaborative public management: Assessing what we know and how we know it. *Public Administration Review, 66,* 33–43.

McGuire, M., & Agranoff, R. (2011). The limitations of public management networks. *Public Administration, 89*(2), 265–284.

NHS England. (2015). *Five year forward view*. London: NHS England.

Owen-Smith, J., & Powell, W. W. (2008). Networks and institutions. *The Sage handbook of organizational institutionalism* (pp. 596–623). London: Sage.

Pollitt, C. (2009). Bureaucracies remember, post-bureaucratic organizations forget? *Public Administration, 87*(2), 198–218.

Rycroft-Malone, J., Wilkinson, J., Burton, C. R., Harvey, G., McCormack, B., Graham, I., & Staniszewska, S. (2013). Collaborative action around implementation in collaborations for leadership in applied health research

and care: Towards a programme theory. *Journal of Health Services Research & Policy, 18*(3_suppl), 13–26.

Scott, J. (Ed.). (2002). *Social networks: Critical concepts in sociology* (Vol. 4). London: Taylor & Francis.

Sheaff, R., & Schofield, J. (2016). Inter-organizational networks in health care: Program networks, care networks, and integrated care. In E. Ferlie, K. Montgomery, & A.-R. Pedersen (Eds.), *The Oxford handbook of health care management* (pp. 434–458). Oxford University Press.

Strong, P., & Robinson, J. (1990). *The NHS under new management*. Milton Keynes: Open University Press.

Waring, J., & Crompton, A. (2019). The struggles for (and of) network management: An ethnographic study of non-dominant policy actors in the English healthcare system. *Public Management Review, 22*(2), 1–19.

Waring, J., & Currie, G. (2009). Managing expert knowledge: Organizational challenges and managerial futures for the UK medical profession. *Organization Studies, 30*(7), 755–778.

Waring, J., Bishop, S., & Roe, B. (2017). Network contra network: The gap between policy and practice in the organisation of major trauma care. In M. Bevir & J. Waring (Eds.), *Decentring health policy* (pp. 102–120). London: Routledge.

Waring, J., Crompton, A., Overton, C., & Roe, B. (2020). Decentering health research networks: Framing collaboration in the context of narrative incompatibility and regional geo-politics. *Public Policy and Administration*. https://doi.org/10.1177/0952076720911686.