Briefing paper for the Mid Staffordshire NHS Foundation Trust Public Inquiry
Seminar on development and training of trust leaders

Issues in the training and development for effective boards in the NHS

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1. Background and scope of paper

Boards carry the ultimate responsibility for the quality of care provided by their organisation and for overall performance. The many patient stories in the Independent Inquiry into care at Mid Staffordshire NHS Foundation Trust 2005 – 2009 (The Francis Report, 2010) provided evidence that the board failed in this regard. In the light of the remit of this public inquiry, inter alia, to draw lessons for the wider health system, this briefing paper offers insights about how boards in the NHS might develop in order to discharge this responsibility more consistently in the future. To shape our thinking, we examine wider questions about the role, purpose, and impact of boards on organisations. We acknowledge that there are continuing debates and an incomplete understanding about what constitutes an effective board in terms of composition, focus and behaviours, reinforced by the many high profile corporate failures, from Maxwell to Enron, as well as the recent banking crisis for which boards have been blamed. Within the context of these uncertainties, the paper draws on the history of NHS boards and other healthcare boards, theories about the purpose and role of the board, the evidence about effective board working, advice and guidance available to boards, and the impact of approaches to whole board development. It concludes with the identification of issues and questions relating to the scope of recruitment and training of board members.

2. History of NHS boards

The history of boards in the NHS mirrors to some degree the different phases of the NHS described by Newdick and Smith (2010) in their report on the structure and organisation of the NHS for the Mid Staffordshire public inquiry. From the establishment of the NHS until 1990, boards of NHS organisations approximately corresponded to the stakeholder model described below in the main theories about boards. Whether they were district health authority boards charged with providing health services across a geographical area, or family practitioner committees responsible for the contracts of general practitioners, opticians, pharmacists and dentists, they were large (between 20
– 30 in total) and included local government elected members, representatives of voluntary organisations, trades unions and the healthcare professions. Neither any of the senior officer team, nor the most senior officer, the district administrator (subsequently general manager and chief executive) served as a member on the board but acted as secretary to the board as well as accounting to the board for the performance of the organisation. In practice, the senior officer and his or her team wielded considerable power in terms of shaping the agenda and effecting decision-making, partly because the large size of the board meant that meetings were often heavily ritualised.

From 1991, with the advent of the internal market, all boards in the English NHS adopted the structure and function of the Anglo-Saxon private sector unitary board model which predominates in UK and US business (Ferlie et al, 1996, Garratt, 1997). The smaller unitary board, ranging in number from 11-15, typically comprises a chair, chief executive, executive directors and a majority of appointed independent (or non-executive) directors. All members of the board take collective responsibility for decisions. It is not clear whether this structure fits the purpose of NHS boards or how or why it was arrived at.

Having adopted a private sector business model in place of the stakeholder model for its local bodies in 1990, the English NHS, via guidance from HM Treasury, moved to embrace lessons from the corporate failures of the 1990s. A number of reports emanating from these failures were used to strengthen corporate governance in the NHS. These included Cadbury (1992) on separation of chief executive officer (CEO) and chair roles, Greenbury (1995) on remuneration committees, Turnbull (1999) on internal control, risk and controls assurance, Higgs (2003) on the role of the non executive director and Walker (2009) on board challenge. With the wisdom of hindsight, it could be argued that the relevance and sufficiency of these reports when applied to the domain of publicly funded and delivered healthcare was never examined in depth.

In a separate and parallel development, NHS Foundation Trusts, first established in 2004, are independent public benefit corporations modelled on co-operative and mutual traditions, which now cover more than half the acute hospital and specialist mental care providers in England (Monitor, 2010:51). The governance structure of Foundation Trusts comprises two boards – a board of governors (up to about fifty people) made up of people elected from the local community membership, and a board of directors (around eleven people) made up of a chair and non-executive directors appointed by the governors, and a chief executive and executive directors, appointed by the chair and approved by the governors. This whole structure resembles the Anglo-Saxon unitary board model we have seen adopted by the English NHS, but, somewhat curiously, nested within a two-tier European or Senate model, commonly found in the Netherlands, France and Germany.

3. **Other types of healthcare boards**

The Senate model comprises a lower-tier operational board which deals with management and strategic issues and an upper-tier supervisory board which ratifies certain decisions taken by the operational board, sets the direction and represents the different interests in the company, particularly those of shareholders and employees (Johnson, Scholes and Whittington, 2005). This model can be seen for example in Germany and a variant in the public hospitals in the Belgian
system which have a four part governance structure comprising a constituent authority, hospital board, executive committee, and medical council (Eekloo et al, 2004).

In an example of a wholly non executive board, New Zealand has 20 District Health Boards tasked with strategic oversight of local health services, but in this case all eleven people on the board are non executive directors: seven are elected by the local population at the time of local government elections and four are appointed by the Minister of Health; the chief executive is appointed by and accountable to the board but is not a board member (www.moh.govt.nz/districthealthboards). This mirrors the governance arrangements typically found in the voluntary sector where there are boards of trustees, and employed staff such as administrators or directors are invited only ‘in attendance’ to boards.

From the US perspective, Pointer outlines four types of boards commonly found within US healthcare. Parent boards govern free-standing independently owned institutions; subsidiary boards are local boards of large enterprises; advisory boards provide steer and guidance without a formal corporate governance role; affiliate organisation boards serve their members’ interests. There are 7,500 hospital and health system boards in the US – part of an economic and social system which supports 5.5 million boards altogether, or one for every 45 citizens (Pointer, 1999).

Within the four home countries of the UK, with the advent of devolution, there have been deepening policy differences (for example in the role of the market) and an increasing divergence in the structures for managing health services. The Welsh board model is stakeholder-based with up to 25 members on each board, resembling the English NHS pre-1990. Scotland has an integrated health model and a unified board structure with strong local authority representation and is experimenting with democratic elections on to boards.

The above illustrates the broad range of board structures and models in use in health services and demonstrates the highly contextual nature of the board form chosen. There are non-executive boards, executive boards, 2 tier boards and unitary boards; there are models for different health service purposes: for insurers, commissioners, providers and for partnerships (cross public sector and public/private). Board membership is achieved through different processes of nomination, appointment and election, and can be paid or unpaid.

The development of these models of boards are firmly rooted in wider traditions surrounding best practices in governance. They relate to beliefs about the purpose and functions of boards which are encapsulated in the main theories outlined below and which board members may hold in their head, subliminally, as they enact their roles on boards.

4. **Theories about boards**

Boards were developed as a result of the industrial revolution, the growing commercial complexity of business and the gradual separation of ownership from control. Boards represented the interests of absent owners or shareholders (the principals), and management became the agents of the board (Pointer, 1999). The earliest theory about boards was thus **agency theory** which is predicated on the notion that the shareholders’ and managers’ interests are likely to be different and that the behaviours of both sets of actors are characterised by self-interested opportunism (Berle and
Means, 1932). Other theories developed later, and are reviewed extensively by Cornforth (2003). These include managerial hegemony (according to which the managers rather than the owners make the key decisions), stewardship theory (in which managers and owners share a common agenda and work ‘side by side’) resource dependency theory (in which the main role of the board is to maximise benefits of external dependencies), and stakeholder theory, according to which board members represent the different interests of members with a stake in the organisation.

Models of board behaviour can be related to the (sometimes unconscious) espousal by individual board members of these different theories. Agency theory, which held sway until recently, is connected to a ‘challenge and compliance’ set of behaviours, in which, for example, subject to perceived hostile challenge, the executive director can seek refuge in the defence of her/his paper.

Stewardship theory relates to a high trust and collaborative style of working, with the disadvantage of times of being characterised by high levels of trust coupled with low challenge. In a stakeholder model, board members tend to be most engaged when articulating the interests of ‘their’ constituency.

A resource dependency model, with members appointed for their external connections and political and social capital, can end up with too many VIPs, resulting in a ‘trophy’ board. With managerial hegemony, the board is disempowered by a chief executive and executive team who control the agenda, and predetermine the outcome of meetings, with the board reduced to rubber stamping.

None of these models are of themselves, in all circumstances, right or wrong, but dysfunctional boards can occur, whatever the composition and structure, when there is a conflict between members about what the fundamental raison d’etre of the board really is or where there is a disjuncture between the prevailing context and circumstances and the disposition and characteristics of that board.

Related to this are theories about the sources and use of board power, including the power of the chief executive (Herman, 1981), the discretionary effort and skill exercised by non executive board members (Pettigrew and McNulty, 1998), and the increased role of the board in periods of crisis or transition (Lorsch and MacIver, 1989) which can be followed by ‘coasting’ according to the stress/inertia theory (Jas and Skelcher, 2005). These ideas suggest that board members have enormous discretion, whatever the governance arrangements, about how they deploy their power and skill for the benefit of the organisation (and in our case, for the benefit of patients)

5. **What do boards do?**

Building on the main theories, much has been written about the main tasks of boards. The shortest version we can come up with, which also relates to classic definitions of corporate governance, is:

- Determine strategy (direction)
- Assess performance (control)
- Shape organisation culture (values, rules, tone)
Covering the first two elements, Garratt suggests there are two main dimensions of the board’s role, what he calls ‘conformance’ and ‘performance’. Conformance involves two main functions: external accountability including compliance with legal and regulatory requirements and accountability to shareholders or other stakeholders, and supervision of management through oversight, monitoring performance and making sure that there are adequate internal controls. This conformance dimension matches quite closely with the agency theory perspective on governance. By contrast, the performance dimension is about driving the organisation forward to better achieve its mission and goals. This again consists of two main functions, policy formulation and strategic thinking, to take the organisation forward. The performance dimension is in keeping with stewardship theory of corporate governance. These four main functions of boards are shown diagrammatically in figure 1. This framework suggests that boards need to be concerned with both the conformance and performance dimensions of corporate governance.

**Figure 1: The main functions of boards** (adapted from Garratt, 1997:45-7)

<table>
<thead>
<tr>
<th><strong>External focus</strong></th>
<th><strong>Short term focus on ‘conformance’</strong></th>
<th><strong>Long term focus on ‘performance’</strong></th>
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| Accountability     | • Ensuring external accountabilities are met, e.g. to stakeholders, funders, regulators.  
• Meeting audit, inspection and reporting requirements | • Setting and safeguarding the organisation’s mission and values  
• Deciding long-term goals  
• Ensuring appropriate policies and systems in place |
| **Internal focus** | **Supervision**             | **Strategic thinking**                  |
|                    | • Appointing and rewarding senior management  
• Overseeing management performance  
• Monitoring key performance indicators  
• Monitoring key financial and budgetary controls  
• Managing risks | • Agreeing strategic direction  
• Shaping and agree long-term plans  
• Reviewing and deciding major resource decisions and investments. |

The Langlands review published by CIPFA(2005) produced six core principles for good governance to guide the work of public service boards (see Figure 2 below). This ‘good governance standard’ indicates both core style and key content for board work in the public sector, and comes closest to the iterative and cyclical framework that authors working from the commercial sector advocate.
Figure 2: How far does the board of your organisation meet the tests of the Good Governance Standard? (CIPFA 2005)

1. Good governance means focusing on the organisation’s purpose and on outcomes for citizens and service users
   - What is this organisation for?
   - What is being done to improve services?
   - Can I easily find out about the organisation’s funding and how it spends its money?

2. Good governance means performing effectively in clearly defined functions and roles
   - Who is in charge of the organisation?
   - How are they elected or appointed?
   - At the top of the organisation, who is responsible for what?

3. Good governance means promoting values for the whole organisation and demonstrating the values of good governance through behaviour
   - According to the organisation, what values guide its work?
   - What standards of behaviour should I expect from the organisation?
   - Do the senior people put into practice the ‘Nolan’ principles for people in public life (selflessness, integrity, objectivity, accountability, openness, honesty, and leadership)?

4. Good governance means taking informed transparent decisions and managing risk
   - Who is responsible for what kinds of decisions?
   - Can I easily find out what decisions have been taken and the reasons for them?
   - Does the organisation publish a clear annual statement on the effectiveness of its risk management system?

5. Good governance means developing the capacity and capability of the governing body to be effective
   - How does the organisation encourage people to get involved in running it?
   - What support does it provide for people to get involved?
   - How does the organisation make sure that all those running the organisation are doing a good job?

6. Good governance means engaging stakeholders and making accountability real
   - Are there opportunities for me and other people to make our views known?
   - How can I go about asking the people in charge about their plans and decisions?
   - Can I find out how to complain and who to contact with suggestions for changes?
As an alternative, and of particular relevance to the non-profit sector, Chait, Ryan and Taylor (2005) propose a hierarchy consisting of three essential components of governance: fiduciary, strategic and generative. Fiduciary duties, or the monitoring and compliance aspects, relate to the legal responsibilities of board members and to the agency theory of governance. The strategic component relates to the work of the board in setting direction and is closer to the ‘performance’ aspect of Garratt’s two main dimensions of board work. Generative governance is also about performance but it encapsulates leadership through governance and thereby aims for organisational renewal as well as tasks relating to strategy.

Garratt’s and Chait’s approaches emphasise mainly the importance of task and process, with a relative neglect of questions of composition and dynamics. There is an argument that the key to unlocking the ‘black box’ (Selim et al, 2009) of board theories and effective board practices may lie in pursuing insights into three key elements: the composition of boards, the focus of board effort and board dynamics, and that these insights may point to the emergence of new theory for boards.

In relation to the composition of boards, the quest for the ideal board form seems, from the evidence so far, to be a chimera. In a meta-analytic review of board composition, leadership structure and financial performance, Dalton, Daily, Ellstrand, & Johnson (1998) found no links between these, and nor did an analysis a decade later focussing on CEO/ chair dualities and insider/outider composition (Heracleous, 2008). The ‘right’ structure and composition of boards is highly context specific: it isn’t that it doesn’t matter, but what works effectively in certain circumstances will not in others and there is a degree of specificity that is missing from current research.

Board focus appears to be important. The emerging evidence is that high performing boards across all sectors concentrate on shaping strategy, resource identification and use, and talent management (for example Garratt, 1996; Unseem, 2006; Ostrower and Stone, 2005). They also match the weight attached to different board tasks with the prevailing internal situation and external environmental conditions. There are some worrying signs that the strategy space, either carved out for or by them, for boards in the public sector may not be very great (for example Farrell, 2005, and Abbott, 2008). The lessons here appear quite clear: boards should be aware of the balance of time and effort they spend on the issues of strategic direction, strategic choices and talent management as well as on monitoring management and on accounting to stakeholders. The balance of board tasks also needs to be attuned to the external environment and its attendant temporal pressures.

Board dynamics can be conceived as the enactment of process rather than about the process per se. Pye and Pettigrew (2005) suggest that effective boards are more than the sum of their parts and, although this is so far under-researched and poorly theorised, it is the dynamic of board members working together which adds value to the organisation. McNulty, Roberts and Styles (2003) in their report for the Higgs Review of the role of non executive directors in the UK characterise the effective non-executive director as ‘independent but involved’, ‘challenging but supportive’ and ‘engaged but non-executive’. Abbott et al (2008) found that although it was part of their remit, board directors in the health sector often avoided a challenging style in their relationships with the executive but that the influence of non executive directors in sub-committees was more extensive than typically found in the private sector, with roles as critical friends as well as scrutineers. The evidence adds up to a
tentative triadic proposition of board dynamics that is able to incorporate a way of working which combines strong grip on the business within a board climate of high trust and high challenge.

6. Evidence connecting NHS boards with organisation performance

The evidence about relationships between organisational cultures and performance in the NHS is also emerging. This is the subject of another forthcoming inquiry seminar. It is becoming clearer that certain cultural characteristics are associated with better performance (Mannion, 2010). There is also evidence available about the conditions under which boards preside over organisation failures. Inquiries and reviews have repeatedly pointed to a lack of challenge by the board at critical junctures (for example, Deloitte and Touche, 2003; Francis Report, 2010). There are clues from a selective literature review about what boards in the UK public sector might pay attention to (Chambers and Cornforth, 2010). A majority of non executive directors appears to be associated with higher performance in the public and private sectors (ibid). There is evidence that smaller sized boards in the public sector with well functioning sub committees are associated with better performance. Board dynamics is emerging as a significant element, particularly a culture of high trust, high challenge and high engagement. The expertise of non executive directors is important in partnering with managers to shape strategy and in tracking performance (ibid). A report on governance arrangements in the NHS (Storey et al, 2010) suggests that aspects of organisation performance, particularly the use of resources, is associated with the contribution of clinicians, the presence of highly influential non executive directors, and with chief executives who exert moderate to high control but do not behave autocratically. The impact of board members on the quality of services is more difficult to detect (ibid) although a study of US hospital boards reveals an association between board focus on clinical quality and hospital clinical performance (Jha and Epstein, 2010).

Although prescribed as important, there is little evidence however to link positive chair and chief executive relationships (the ‘2 at the top’) with board or organisational performance (Office for Public Management, 2009) although some (weak) evidence from within the NHS (Exworthy and Robinson, 2001) as well as outside (Kakabadse, 2006) indicating that poor relationships between these two can negatively affect board and organisational performance. There is increasing evidence available about the conditions under which NHS boards preside over organisation failures. Inquiries and reviews have repeatedly pointed to a lack of challenge by the board at critical junctures. In the case of the financial meltdown at North Bristol NHS Trust in 2003, Deloitte and Touche reflect on relationship difficulties at board level and a failure to probe the financial situation and to put in place risk management processes (Avon, Gloucestershire and Wiltshire SHA, 2003).

A recent exploratory study (Chambers et al, 2011) examined the characteristics of high performing organisations and distinguishing features of their boards in the NHS. Nineteen health care organisations in England were identified as the top performers using a combination of measures, including staff and patient perspectives, clinical and financial performance. Metrics over several years were scrutinised to exclude sheer good luck or unsustained high performance. Then, from publicly available information, including analysis of board agendas and minutes, key features of these boards were examined in comparison with others. When compared them with other NHS organisations, a positive link was found between high performing organisations and:
• CEOs being in post for longer than 4 years
• Higher number of women on their boards
• Greater contribution of non executive directors at board meetings
• Dominance of specialist/tertiary trusts over other types of organisations

It is important to emphasise that these are links rather than causal factors, but they are important enough for boards to bear in mind as they go about the business of discharging their responsibilities to ensure the care and safety of patients in their organisation. These responsibilities are collective; board members individually also have distinctive roles on the board.

7. Roles of different board members

We have seen that the unitary board model in the English NHS adheres to a principle of collective responsibility. There is an inherent paradox here, as the non executives have a responsibility (see Garratt et al) to hold the executives, the managers in agency theory terms, to account for performance as well as to act in unison with them to set direction, strategy and so on. It is clear that there are four different constituencies, even on a unitary board. These comprise chiefly the chair, non executive directors, chief executive and executive directors. Roles and challenges for each of these groups are described in turn.

The chair of an NHS board is expected to work around three days a week, so although technically a non executive position, in practice straddles the boundary. According the NHS Appointments Commission (2009) the role of the chair includes:

• leading the Board and making sure it works effectively;
• making sure that patients, the public and staff are kept informed about the organisation plans and that their views are listened to;
• making sure that the Board and its members are working well together and as individuals;
• supporting the Chief Executive and making sure the executives and non-executives can contribute to the work of the Board.

Research shows that the chair has a crucial relationship with the chief executive combining trust and challenge, and also in the development of mutual respect, openness and clearly negotiated complementary roles (Exworthy and Robinson, 2001).

The non executive director of an NHS board is expected to work between 2.5 and 5 days a month. According to the NHS Appointments Commission (2009) the role of the non executive director includes:

• to help the board to work in the public interest
• to keep patients and the public properly informed
• to plan for the future to improve healthcare services
• to make sure that the management team meets its performance targets
• to ensure that the finances of the organisation are managed properly, with accurate information.

Although often enthusiastic and engaged, non executive directors have over the years complained that there is insufficient clarity about the precise nature of their contribution. The SAGE acronym was developed to help to frame the focus of their work, with the initials standing for Steward, Ambassador, Guardian and Experience (as reported in Newdick and Smith, 2010). The Higgs Report (2003) has also been helpful in spelling out the distinctive role of the non executive director in contributing to strategy, scrutinising performance, checking financial controls and risk systems and determining senior appointments & remuneration. Higgs also advised on widening the entry gate and pool, better induction and training, performance evaluation, and a new senior independent director (SID) role which Foundation Trusts have taken up, although, anecdotally, not all SIDs are clear about this role.

The final valuable part that non executive directors can play, in the enactment of their role, is as the grit in the oyster, to avoid groupthink. In a discussion on developing strategic competence, Hodgkinson and Sparrow (2002) highlight the dangers of the competency trap in a quotation borrowed from Miller:

“...Before long, there is no noise left in the system: no court jesters, no devil’s advocates, no iconoclasts with any say...” (Miller, 1994)

This may be difficult in situations where non executive directors, even those who have considerable experience and have wielded significant power and authority in their ‘day jobs’, feel uncomfortable in challenging doctors in areas of clinical quality. Experience of the authors of this paper indicate that this may be an issue and in a report on governance challenges for hospices this was also reported for boards of trustees as often a ‘no go’ area (Chambers et al, 2010).

The role of the chief executive on the board is described (as reported in Newdick and Smith, 2010) as:

• ensuring the board is empowered to govern the organisation and that the objectives it sets are accomplished through effective action (NHS Appointments Commission, 2003:30)
• providing operational leadership and ensuring effective control systems
• establishing a culture that is patient-focused, forward-thinking and modernising

NHS chief executives are also the accountable officers for the clinical quality of care, irrespective of their professional background (Sausman, 2001). As highlighted above, there is some research indicating that relationships with the chair of significant importance in ensuring effective board working. Chief executives also have an important role in supporting and directing the contribution of executive team members on boards.

The role of executive directors as board members is not well elaborated. Experience of the authors of this paper suggests that many are not well prepared for taking up the role of corporate board
member in addition to their functional roles as medical director, nursing director, finance director and so on.

For the medical director, there can be tensions between the roles of clinical and corporate objectives. No specific statutory responsibilities are described for this role and the exact division of duties is for boards to decide. It has been argued that the role may even be too large and complex for one person to fulfil (Newdick and Smith, 2010:28-29). In the case of the finance director, as with non-executive directors, there may be underdeveloped confidence in challenging on clinical issues and a reluctance to stray from their area of functional expert professional competence.

There is a possible fifth player here, although not a board member. The influence of the board secretary, described variously as silent servant or eminence grise in ensuring the professional and effective running of the board should not be underestimated. This specialist role is at the centre of the arrangements for corporate governance of the healthcare organisation. The company secretary is a key maintainer and developer of effective systems of good governance within their organisation. This role can be critical in ensuring that the board meets its commitments to a wide and complex range of both internal and external stakeholders. (Benson and Winn, 2011).

The NHS National Leadership Council in 2010 defined the role of the company secretary in the NHS as one which:

- is accountable to the chair.
- ensures good information flows within the board and its committees between senior management and non-executive directors.
- is responsible for advising the board through the chair on all governance matters, including ensuring that the organisation complies with the relevant legislation and regulations (and in Foundation Trusts the terms of authorisation).
- is responsible to the board for ensuring compliance with board procedures, and should be accessible to all directors.
- and specifically for Foundation Trusts, has additional responsibilities to support the council of governors.

8. Advice and guidance available to boards

The Department of Health through its regional bodies (the Regional Health Authorities and subsequently the Regional Offices) was responsible for the recruitment of chairs and non executive directors. The NHS Appointments Commission was established in 2001 to bring independence to the system for recruitment and appointments, to clarify roles, responsibilities and arrangements for formal appraisals, and to offer opportunities for coherent training and development, drawing on best practice recommended for corporate governance in the private sector, although not always adopted there. The Commission was renamed the Appointments Commission in 2006 and its remit extended to include appointments to all bodies in the health and social care sector, excluding Foundation Trusts although it can provide services to these bodies by invitation. The Commission is scheduled to be abolished in 2012 with its responsibilities transferring back to the Department of Health.
The Commission currently procures some training for chairs and non executive directors, particularly induction for newly appointed members, and finance training, and local NHS bodies are encouraged to supplement with programmes of more local relevance. Similarly Monitor, in collaboration with the NHS Institute for Innovation and Improvement, has commissioned training programmes for non executive directors of existing and aspirant Foundation Trusts.

There is no shortage of steer for NHS boards. A recent study of the chair/chief executive relationship, which confirms and updates findings from earlier work on ‘two at the top’ (Exworthy and Robinson, 2001) summarised the literature in general as being dominated by prescription rather than insight (OPM, 2009). The NHS Confederation has identified four key characteristics of effective boards: a focus on strategic decision-making, trust and corporate working, constructive challenge and effective chairs. In their examination of boards at work, however, the authors found that ‘the daily grind’ often obscured strategic decision-making and, whilst there was often a good deal of trust between board members, there was too little constructive challenge, and therefore some missed opportunities (NHS Confederation, 2005).

NHS boards are expected to operate along all four of Garratt’s quadrants from developing a clear vision, to clarifying strategic direction, and also to monitoring performance and accounting to local communities and to government (1997). The key challenges for NHS boards can therefore be segmented into these four quadrants and guidance reinforces this. The Healthy NHS Board (2010) published by the National Leadership Council for example focuses on three main roles of the board: formulating strategy, shaping culture and ensuring accountability with the three building blocks of context, intelligence and engagement. It also emphasizes health system governance across organizations (ibid).

The code of governance for NHS Foundation Trusts published by Monitor (2010) in echoes of research relating to effective board working outlined above, emphasises the principle of collective responsibility, the need for a sound committee structure, good quality information and external advice, productive relationships with stakeholders and the development of board effectiveness.

9. **Board development**

Cornforth suggests that reflexivity compensates for the impossibility of achieving an ‘ideal’ board structure or generic ‘rules’ for board effectiveness, and defines reflexivity as the process of achieving a better understanding of behaviours, roles, teamworking and impact of the board (Cornforth, 2003). West proposes that reflexivity provides the space to promote team health, creativity and robust challenge to the existing ways of doing things that is essential for innovation (West, 1997). Boards sometimes seek external support to help them in this task and may also embark on a wide-ranging organisation development programme of which development of the board is only a part.

Using Garrett’s board tasks model (see Fig 1 above) it is possible to construct a framework for board development which has a degree of relevance for all boards. An exploratory study to determine the utility of this for NHS boards revealed that, with refinements related to levels of maturity, espousal and practice of values and intelligent commissioning of facilitation of board development, the model had both resonance and relevance (Chambers and Higgins, 2005).
Since then, there has been much board development activity, some of it led by the NHS Institute for Innovation and Improvement, and some by management consultancies, but no research into the scope and effectiveness of different tools for board diagnostics, assessment and development. Outside the NHS, some studies of board development support the contention that board development is worthwhile. Brown (2007) for example, in a large study of credit unions, found that board development practices do lead to more capable board members and the presence of these board members tends to explain board performance. Holland and Jackson (1998) in a smaller matched comparison study in the non profit sector found that board development was associated with significant improvements in board performance in the experimental group in comparison with the control group.

10. Issues in the training and development of effective boards in the NHS

This examination of the background relating to NHS boards has led us to identify a number of issues and questions surrounding the construction, and the training and development of NHS boards:

i) The rationale and evidence-base for the 1991 model for NHS boards has never been set out in an adequate manner. It could be argued that in some NHS senior management circles, the small private sector unitary board concept was never fully accepted. The two tier Foundation Trust model provides a challenge to it. Emerging governance arrangements for clinical commissioning groups when they become statutory bodies, with a chair drawn from the GP community, and a potential requirement for only two non executive directors represents a further significant step away from this model. Evidence from outside the public sector does suggest however that some elements of this board model are associated with improved organisation performance. In the light of this enduring uncertainty, it would be advisable to move away from a tendency to ‘faith-based’ and exhortative approaches to guidance, training and development. Is it time for a root-and-branch inquiry into the composition and structure of NHS boards?

ii) The evidence about effective board working suggests that there are some key principles but also that local circumstances are really important in steering the focus and behaviours of effective boards. A rigid separation between strategy and delivery may not for example be helpful in the context of a healthcare provider organisation, whereas it might be appropriate for an organisation with a very different mission. The focus for boards in specialist mental health is likely to be different from that of general acute hospitals, and different again specialist and tertiary bodies. Board assurance processes will need to match the likely risk and the likely impact of failure to deliver objectives. How do we get the balance right between national standards for recruitment, training and performance of board members and locally developed arrangements which have a fit with local needs and requirements?

iii) There is an emerging proposition that boards in the NHS need to embody a culture of high trust across the executive and non executive divide, together with robust challenge, and a tight grip on the business of delivering high quality patient care in a financially sustainable way. In the light of evidence from this Inquiry, should we be focusing and
prioritising training and development for boards in this third area? How can individual and collective board performance on this be measured?

iv) Another briefing paper for this seminar on regulation of NHS managers (Smith and Chambers, 2011) highlights the potentially enhanced contribution of the Code of Conduct for NHS managers and the possibility of the instigation of a ‘fit and proper person’ test. **How could boards and particular chairs of boards ensure that this is enacted?**

v) With the demise of the Appointments Commission in 2012, there will no longer be an independent body overseeing appointments and training. There is an argument that although it can point to some achievements, the influence of the Commission did not go far enough in eliminating unacceptable variation of the performance of boards in the NHS. **What options does the Department of Health have as it resumes responsibility for this area of work again?**

vi) The training of chairs and non executive directors has arguably attracted more attention than that of chief executive and executive directors in their roles as board members. **What are the merits of different models of training and development for board members, individually and collectively, and across the different constituencies of the board?**

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**About the authors**

Naomi Chambers is professor of health policy and management and head of the health group at Manchester Business School at the University of Manchester. Her teaching has been focussed on the design and delivery of leadership programmes for the NHS, including for NHS chairs and non executive directors, and she currently directs a programme for non executive directors of existing and aspirant Foundation Trusts. She holds a grant of £50k from the Department of Health Service Delivery and Organisation Research Programme as a principal investigator for a study examining the evidence about board governance, board effectiveness and board development. Since 1997 Naomi has been a non executive director of a health authority in Derbyshire, a mental health trust in Manchester and currently is non executive director of North Staffordshire Primary Care Trust (serving the population of Staffordshire Moorlands and Newcastle under Lyme) until 30 November 2011.

Judith Smith is Head of Policy at the Nuffield Trust, an independent charitable research foundation in London. She is an experienced and widely published health services researcher and policy analyst. Before joining the Nuffield Trust in 2009, she worked at the Health Services Management Centre, University of Birmingham where she was Senior Lecturer and Director of Research. Over the period 2007-2009, Judith undertook a visiting research fellowship at Victoria University of Wellington in New Zealand, studying the funding and organisation of primary care. At the Nuffield Trust, she leads a team whose research focuses on the
development and effectiveness of commissioning in the NHS, the quest for better integrated care, the role and potential of physician organisations, and the search for health system efficiency in the economic downturn. Judith’s other roles include being a member of the board of the UK Health Services Research Network, and she holds visiting senior academic posts at the University of Birmingham, the London School of Hygiene and Tropical Medicine, and the Victoria University of Wellington.

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