

Centre for Innovation
in Health Management



UNIVERSITY OF LEEDS



**National Inquiry into
Fit for Purpose Governance
in the NHS**

CHM

Short report

Introduction

The system of governance through NHS boards offers the potential for excellent governance, however many board members are unclear what governance actually is and how to do it. Against this backdrop and because of a growing interest in the role of boards of directors in both the public and private sectors the Centre for Innovation in Health Management decided to run a national inquiry into governance and boards in the NHS. The CIHM identified a series of questions crucial to understanding how boards can make a greater contribution to the NHS. These questions are grouped into two areas:

- An overview and investigation into the impact of governance principles and arrangements on the NHS
- An in-depth scrutiny of how boards can improve the work of NHS trusts

In the private sector the role of boards of directors is obvious – they safeguard the interests of shareholders and protect the company's bottom line. But in the public sector the role of the board is not as clear cut. Boards' primary purpose is to create public value and they have two major roles in this. Firstly, being at the centre of a network of stakeholders they play a vital role in defining and clarifying what the public actually values as they inevitably take contested decisions about the allocation of resources. Secondly, they are accountable for the performance of their organisations and the outcomes of service delivery.

NHS boards must also deal with the politics of the NHS, government and their local communities. The NHS as a whole has been subject to a huge amount of structural change which has led to a culture of crisis on the board. The often fraught relations between the medical professional and managers have led to problems being tackled in a linear, expert way, ignoring the multiplicity of perspectives on NHS trusts.

We believe our findings offer real insights into how boards are operating, the challenges they face and possible routes for improvement.

Methodology

The research method was modelled on the co-operative inquiry mode and involved three workshops which comprised focus groups, whole group discussions and other activities. The inquiry team held five formal meetings and feedback from the inquiry participants on the findings was also sought.

The first workshop brought together 27 NHS board members and governance professionals from 13 different NHS organisations in the north east of England. The second workshop was directed at the 'shapers' of governance and involved representatives from the Department of Health, strategic health authorities, commissions and a few independent consultants. The third workshop brought the two groups together. Participants were selected according to their job, experience and familiarity with governance matters.

Inquiry findings part one: governance and the NHS

Governance is the place where the external political process gets translated into managerial behaviour – that is, into strategy. Strategy requires making sense of the external and internal context; working out what the choices are and what relationships are needed to deliver those choices; determining accountability boundaries (what the organisation is accountable for) and principles (how the organisation will exercise choices) that allow solutions to emerge in the organisation, and with stakeholders, and that allows managers to take decisions that contribute to the strategic direction.

Governance is about defining the purpose, role and values of the organisation. Management is deciding how to deliver services to match this. However, many board members do not understand the difference between governance and management, and are puzzled by the different models in the public sector.

Governance is an inherently political process – making choices about public resources. However, we found that for people working in the NHS, politics and politicians were the problem. Board members see politics as "dirty work" and try to ignore it as much as possible. As a result they spend far too much time focusing internally – down and in, rather than externally – up and out.

The complexity board members face is that the internal dialogue is difficult – for example, tensions between clinicians are difficult enough to manage without



opening them up to the outside world. For boards, the political context over complicates already difficult work. However diverse views and co-produced solutions are the answer to the major challenges boards face.

Boards that are successful politically rely on dialogue and co-operation with a range of people and organisations. This requires them to be open to public scrutiny of their decisions. This leads to the notion of co-production, where individuals and the community play a part in making decisions about treatments and care choices with clinicians and managers.

Inquiry participants' knowledge of the patient experience was varied with one 'shaper'¹ of governance admitting that the patient is not at the centre of the board agenda. So, it is imperative that governance starts from a clear view of what's going on in the organisation and what the patient's/carer's/community's experience of the NHS is. Part of this is also about taking into account and being honest about the gap between what patients want and what is being achieved.

Marrying this local perspective with the national political context is crucial. Again, this requires attention to the 'up and out,' rather than simply the 'down and in.' In the workshops we found the internal short-term perspective was crowding out the long-term perspective. However, this is down to choice and boards must choose where they focus their attention. Successful boards are engaged in the policy process as well as the patient's journey.

Again, we found a tension between doing assurance work (risk management and performance management) and creating an environment which encourages innovation. Coupled with this is a culture where challenge and confrontation in the board is discouraged. Boards do not like tension and ambiguity

– both of which we believe can be positive forces, and are necessary components of board work – and look for ways to manage them out.

Board members also have to make sure that they have got the basics right – quality of care and finance – and in doing so they create the conditions for innovation. One 'shaper' told the inquiry that good governance is about always endeavouring to keep improving.

To work successfully boards need legitimacy. They need to be comfortable about making contested decisions and about those decisions being open to public scrutiny. Many of our participants struggled with the notion of accountability – 'accountable to who and for what?' they asked. Boards need to have their own coherent story about their distinctive and legitimate role.

Modern health care is delivered by teams of professionals across different organisations – governance needs to travel through the system with the patient.

Diverse views – including from these organisations – are the source of possibility and adaptation. The diverse experience and talents of non-executive directors and executive directors add to the ability of the board to govern well. However, the experience of those outside the medical profession and NHS sphere is often not fully utilised.

We asked board members to tell us about a time when governance 'worked' in their organisation. All the examples given were of a crisis. Everyone pulled together, agreed what to do, drove the solution and achieved success in the short term. We believe this shows the dominance of the 'expert' model in the health service, which the NHS falls back on when a problem arises. Expertise is valued and rewarded. When there is a problem the person with the

knowledge tells the people without that knowledge what to do. Also being effective in the face of crisis is very different from being effective all the time.

Problems faced at board level require collaboration and co-production. Most of these problems are 'wicked' – that is, they are hard to understand in terms of boundaries and root causes, and require engagement and time to bring out solutions. The NHS has a tendency to split problems up into 'tame' solutions: problems that can be easily identified and solved. Health care organisations are made up of groups of professionals who are highly specialised and have sector specific values and behaviours. Not surprisingly complex issues are broken down, boxed and treated separately, depending on who the potential "expert" is. This leads to an overreliance on governance of the parts, rather than governance for the whole of the Trust.

This idea reinforces individual responsibility over collective board responsibility. The inquiry found that when talking individually people seemed energetic, but collectively their energy dipped. From the workshops we found that what boards need to do to work better as a collective is improved understanding of each other; clarity about what they are there for and what the work is; better access to information and data about what's actually going on now; skills in giving and receiving feedback.

¹ By 'shaper' we mean a senior leader or an organisation which influences how Governance is operated in the NHS. They could do this through developing policy, by setting rules, by performance management – examples include SHAs, The Audit Commission, CONFED



Inquiry findings part two: How can NHS boards be more effective?

The second part of the inquiry presents research findings on the operation of boards. We have grouped the findings into five headings which show how boards are working and what improvements could be made.

1. Board dynamics: Do NHS boards function as a set of individuals or as a collective unit?

Our first finding was the excessive focus on the relationship between the trust chief executive and board chair to the detriment of the board as a whole. The chief executive is often seen as running the business and the chair as running the board with the directors playing supporting roles. We heard of chairs and chief executives holding private meetings and directors who were unwilling to openly challenge the chief executive and chair.

While not wanting to downplay the importance of these two figures we believe that they provide direction, protection and order for followers which can help in dealing with 'tame' problems, but not when dealing with 'wicked' problems which need a multiplicity of views.

We also found too much emphasis on the structure of the board, with an excessive concern, for example, on the number of directors and number of board meetings, rather than on the processes and dynamics of the board. Of course, it is easy to be prescriptive about structures but relationships and the design of meetings i.e. how to have difficult conversations, are less well understood.

Another problem is the lack of engagement with board matters by both executive and non-executive members. Executive members see their role on the board as an add-on and see little benefit for them in terms of their career. One chief executive told of executives sabotaging meetings by providing 25-page documents and giving very long answers. Non-executives are poorly paid compared to private sector counterparts and are not given enough information or training to carry out their role properly. Both these issues perpetuate the dominance of the chair and chief executive.

Other problems with board dynamics are tensions between CEO and chair, and the executives and non executives. Time and effort needs to be spent to understand these tensions to ensure that they are not negative.

To overcome these problems we propose:

- The establishment of a design team for the board, made up of a small group of board members, given the brief of analysing the board and working up a process for improvements in board decision-making. The team should be made up of a few board members with a clear brief, setting out parameters and expectations. The team should highlight areas of structure, process, style and interpersonal dynamics and work out how to design meetings to improve these
- Board members should invest time in understanding each other, making the most of what each has to offer. Socialisation can lessen the likelihood of board members splitting into factions and expose tensions. Better understanding of all members should also weaken the chair/chief executive stranglehold on the board.

2. Board processes: Is there a lack of conflict/ challenge at board level?

We found a real lack of understanding between clinical professionals and managers at board level. This leads to a situation where a number of board members are seen as expert and others are, at best, informed amateurs. Unless efforts are made to ensure that all board members have enough knowledge or feel safe expressing that lack of knowledge it will be difficult to harness the varied skills and expertise of all board members.

A further consequence of the divide between doctors and managers is that challenge is frowned upon and alternative ways of doing things discouraged. This is a particular issue for non-executive directors – if they do not challenge the clinicians they are failing to do their job.

Coupled with this divide is the poor quality of data provided to board members. How can directors challenge each other if they do not have the information to back up their questions? A lack of information about what is actually going on now in the Trust, enables a power status quo to be maintained and for the board to be driven from the top down.

This lack of data, along with a lack of engagement of all members, drives two further findings. Firstly, if there is an information vacuum, directors will struggle to raise or discuss organisational strategic requirements. A second associated issue is a failure of internal channels of communication and information sharing. If the board is run from the top, if there are natural tensions within the board and if data is an issue, and if skills in feedback and conflict are missing there will be communication failure. Board members will be unaware of what is happening in the organisation as a whole. Similarly decisions might be made at board level and not spread throughout the organisation.

A final finding in this area was a lack of engagement with external and internal stakeholders, with participants talking of situations where a failure to consult staff had resulted in resentment.

To overcome these problems we recommend:

- Ensuring there are deep and open information sharing across the organisation. Challenge can be harnessed and ambiguity managed if this is the case.
- Commitment to a challenge and questioning. Once board members have good enough information a process of critical inquiry should be embedded in board practice. This culture of open and constructive challenge should be a model for the organisation.
- Regular reviews and debriefs of board meetings and committees to highlight what areas of board process need attention. Practice and reflection leads to improvements.



3. Responsibility vs. accountability: Is there a refusal to take individual responsibility? Is there too much focus on accountability?

Successive governments have instilled a targets culture in the NHS and board members often lack the experience to move from simple accountability – a box ticking approach – to taking responsibility for their actions. This is exacerbated by two factors. Firstly, measures and money have an immediacy unlike more general notions of health. Secondly, there is no clear link between activity and outcome in terms of health. So attention will naturally be pushed to easily defined and measured outcomes.

This emphasis on accountability is compounded by the issue of ill-defined objectives and a lack of understanding or appreciation of the role of governance and how it adds value to the organisation. Governance is not to do with the day-to-day management of the organisation or ensuring that targets are met. Governance is the creation of the culture and environment which ensures the organisation meets its goals.

An emphasis on accountability can be a defence – a focus on accountability and specific measures shifts the organisation away from constantly searching for ways to improve. There is a prevailing view that if something is not measurable then it is not important. A focus on accountability can also lead to vested interests – if cleanliness, for example, is an important target resources can be directed towards that without regard for the knock-on effects in other areas.

Accountability can also lead to a blame culture where individuals are deemed 'guilty' and are punished without the organisation as a whole learning from what are usually system's (collective) mistakes. Given the complex and interrelated nature of the NHS it is unlikely that there is ever a single cause for outcomes. A culture where there is a lack of personal responsibility also leads an unwillingness to take risks, with people becoming defensive in their decision making, which in turn discourages innovation and experimentation.

As a solution we recommend:

- Learning - organisations must accept that mistakes will happen but, when they do, ensure that the whole organisation learns from them. Board members have to take personal and collective responsibility for their behaviour and action. There also has to be a sense that in the trust the buck stops with the board.
- 'Feedback loops' – to generate an evidence-base for decisions. This means tracking the impact of decisions, and reviewing those to see if they had the impact they were supposed to, and if not why not. This is how an organisation progresses.

4. Boards and directors' role: What are the roles of the director and the board of directors, and are directors able to work on behalf of the board and organisation?

Trust boards provide leadership and direction and they are only effective if they are open to constructive challenge and debate. To add value to the organisation the board needs to establish for itself a defined and recognised role within the organisation. It is important that clarity of purpose is achieved which will then transmit itself to the rest of the organisation.

In fulfilling its role the board must overcome two serious obstacles. First, it must offer a consistent set of messages. Second, it must set up communication channels to people both inside and outside the trust. One of the biggest failings of most boards was a tendency to work in isolation from the rest of the organisation and the outside world. In communicating with the organisation the board needs to be aware of all the different parts and different ways of communicating. The board needs to stay focused on the external environment to ensure that it carries out its strategic objectives effectively.

NHS boards have to be responsible for both service delivery and act as a cushion between central government and their own trust. We propose that:

- Boards develop the capability to engage with the policy context to make the right decisions for their own trust. Part of this is ensuring boards have the right mix of skills and experience and that recruitment procedures are robust. Non-executive directors have to be clear what is required of both the board and themselves and use their own contacts for the good of the organisation. Part of this is working hard on engagement processes as part of its strategic work.

5. Board performance: Does the dominance of performance management in the NHS crowd out the wider value of directing and governing the organisation?

Performance management and governance by targets leads board directors to become passive observers rather than designers of the governance system of their organisation. It is all too easy to fall into a trap of ticking boxes and responding to the latest policy initiative from government, rather than concentrating on improving health.

There are inherent tensions between the performance management culture and improving health – financial performance provides measurable and demonstrable targets, which are much easier to measure than clinical quality. Managers complain that the system does not measure the real work done by trusts.

One NHS chief executive told the inquiry: "We don't think that core standards are measured in the way the service is provided. Core standards are structured to find out what structure and systems are in place, but they do not demonstrate the outcomes of these processes and the results of the operations. I think this a real fundamental fault in the current governance systems."

There has also been a strong focus on demonstrating good financial management – another highly measurable and demonstrable target.

It has been known for health managers to manipulate trusts' performance measurements to present outcomes in a better light. This has driven trusts to expose good performance and hide poor performance – diminishing any possibility for learning from mistakes and therefore improvement.

To overcome the dominance of performance management we propose that:

- Boards establish a unique and important role for themselves as the custodians of the values of the NHS. In driving the performance of their trust the board has to marry the emphasis on performance management with concern for the welfare of patients. The board has to set the climate for operational performance, and has to be the strategic guardian of the organisation.

Given central government's political imperatives this role is no easy task but if boards take on some of the suggestions from the previous sections there is a fighting chance that the NHS and its patients will get the governance it deserves.



Conclusion

The governance model we have suggested is intended to enhance the role of the board. The participants we met demonstrated that boards, even when put under considerable pressure, can and do deliver. We are not arguing for a wholesale cull of board members – we believe that success is a matter of better ‘design’ and making the most of the skills and experience of the members of NHS boards.

These are our principles of governance for NHS boards

- Our Business is Health – be absolutely committed to the purpose
- Ask good questions rather than feel the responsibility of providing the answers.
- Performance relates to the ‘tame’ issues – use processes of learning and collaborative working for the ‘wicked’ issues.
- Engage with the political context
- Manage ‘up and out’ as well as governing ‘in and down’.
- Balance assurance and innovation.
- Design board processes that make the most of individuals and embrace differences.
- Confront the brutal facts about the organisation - know what patients are experiencing.
- Design board process that are fit for purpose.
- Ensure auditable decision trails.
- Do the difficult stuff – it takes discipline to get people out of their comfort zone.
- Take responsibility for co-creating the context.
- Find a way of working with the designed-in tensions in NHS governance.
- Take time to understand what each board member can offer; to revisit purpose and context; to review board processes.

And these are our principles for NHS boards practice

- The board is a place for the integration of politics, business and mission.
- This is reflected in the discussion of how to make this possible and transferred into the operational plan for the executive team.
- The board has to connect itself to the success and failure of the organisation.
- The board has to set the enabling tone and the process level of performance for the organisation.
- The board has to model the individual and collective behaviour that is required.
- The board has to represent the voice of the citizen (user, patient, supplier, owner and employee).

Intended audience

This report is for both non-executives, executives and policy makers who are trying to find better ways of governing public services in ways that truly impact patients and communities.

This is an executive summary of a longer report which can be found at www.cihm.leeds.ac.uk

If you would like a printed copy of this please contact us at info@cihm.leeds.ac.uk

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