Centre for Innovation in Health Management

UNIVERSITY OF LEEDS

National Inquiry into Fit for Purpose Governance in the NHS

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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.

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Executive summary

Introduction

Boards are taking on an increasingly important role in the NHS but their definition, objectives and processes are not clear or widely understood. Against this backdrop and because of a growing interest in the role of boards the Centre for Innovation in Health Management (CIHM) has run a national inquiry into governance 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 in 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 – to 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. The NHS board’s role is to create public value and it does this in two ways. Firstly, as a network of stakeholders board members play a vital role in defining and clarifying what the public values as they take contested decisions about the allocation of resources. Secondly, they are accountable for the performance of their organisations and the outcomes of service delivery.

Methodology

To carry out the research we brought together 27 NHS board members and governance professionals from 13 different NHS trusts across the north east. We also talked to the ‘shapers’ of governance, representatives from the Department of Health, strategic health authorities, commissions and a few independent consultants. Participants were selected according to their job, experience and familiarity with governance matters.

Inquiry findings part one: governance and the NHS

The design of governance through NHS boards offers the potential for excellent governance, however many board members are unclear what governance actually is and how it differs from management. Governance is the place where the external political process gets translated into managerial behaviour – that is, its strategy. Strategy requires making sense of the context; working out what the choices and what relationships are needed to deliver those choices; determining what they are accountable for and then handing all this over to managers to decide how to make this happen.

Governance is an inherently political process but 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 spent far too much time focusing internally on the organisation – the down and in, rather than outside the organisation – the up and out.

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 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.

Board governance must start from a clear view of what’s going on in the organisation and what the patient’s/carer’s/community’s experience is. Marrying this local perspective with the national political context is crucial. In the workshops we found the internal short-term perspective was crowding out the long-term perspective.

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 on the board is discouraged.

To work successfully boards need legitimacy. They need to be comfortable about making contested decisions which are open to public scrutiny. Modern health care is delivered by teams of professionals across different organisations – governance needs to travel through the system with the patient.

Diverse views are the source of possibility and adaptation. However, we found that the experience of those outside the medical profession and NHS sphere is often not utilised. When there is a problem the NHS often falls back on the expert model – expertise is valued and rewarded. This leads to an unwillingness to challenge other ‘expert’ board members.

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. We found a tendency to put problems in the ‘tame’ box – complex problems are split up into manageable ones and dealt with by experts.

This idea reinforces individual responsibility over collective board responsibility. The inquiry found that when talking individually people seemed energetic, but collectively they seemed miserable.
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 research findings into five headings showing how boards are operating, the challenges they face and ways they can improve.

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

We found an 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 being unwilling to openly challenge the chief executive and chair.

There was also too much emphasis on the structure of the board rather than on the processes and dynamics of the board.

Executive members see their board role as an add-on bringing little benefit in terms of their career. Non-executives are poorly paid compared to private sector counterparts and are not given enough information or training to carry out their role properly.

Other problems with board dynamics are tensions between CEO and chair, and the executives and non-executives.

We propose the establishment of a design team, given the brief of analysing the board and working up a plan for improvements. We also suggest board members get together outside formal board meetings to explore tensions and ambiguities.

Finally, development of board members is key. Training should focus on the individual director’s role and how they perform as part of a team.

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. This leads to a situation where a number of directors are seen as expert and the others are, at best, informed amateurs.

Coupled with this is the poor quality of data provided to board members. A lack of information enables a power status quo to be maintained.

This lack of information is compounded by poor communication and board members are unaware of what is happening in the organisation as a whole. Similarly decisions might be taken at board level and not spread throughout the organisation.

Lack of engagement with external and internal stakeholders is common and participants talked of situations where a failure to consult staff had resulted in resentment.

To overcome these problems we suggest that boards must be willing and capable of generating challenge and exploiting tensions and ambiguity.

Once board members have the right information a process of critical inquiry should be embedded in board practice and spread throughout the organisation.

We also recommend that board members give and receive feedback and review their meetings.

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

Successive governments have instilled targets culture into 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 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.

An excessive focus on accountability can lead to blame culture where the guilty are identified and punished without the organisation as a whole learning from mistakes. This lack of personal responsibility also leads an unwillingness to take risks.

To overcome these problems we propose that organisations must accept that mistakes will happen but, when they do, ensure that everyone learns from them.

We also propose “feedback loops” – where it is legitimate to contest decisions, errors and mistakes are reviewed and discussed. This is how evidence-based decision making happens.

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?

The board needs to establish a defined and recognised role within the organisation and offer a consistent set of messages.

One of the biggest failings of most boards was a tendency to work in isolation from both the rest of the organisation and the external environment. NHS boards have to be responsible for both service delivery and act as a cushion between central government and their own trust. Boards need a range of skills and experience to be successful at this.

We propose that boards develop the capability to engage with the policy context to make the right strategic decisions for their own trust.

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. It is all too easy to fall into a trap of ticking boxes and responding to the latest policy initiative to come 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.

To overcome this we propose that boards establish themselves as the custodians of the values of the NHS. The board has to be the driver of operational performance and the strategic guardian of the organisation.
Conclusion
We are not arguing for a wholesale cull of board members – we believe that success is a matter of making the most of the skills and experience men and women already sitting on NHS trust boards.

These are our principles for governance for NHS boards

Our Business is Health – be absolutely committed to the purpose.

Ask good questions rather than have to provide 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 processes that are fit for purpose
- Ensure audible 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

- 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.)

Introduction
As the world economy becomes more turbulent and the role of government evolves, good organisational governance becomes more important. This is not only true in the private sector, but also in the public sector, where health and social care is no longer provided solely by the state but also by independent and quasi independent organisations operating in a fast changing regulatory environment. The public sector has to take customer focus seriously and must promote service innovation in efficiency effectiveness and user sensitivity.

Against this background the Centre for Innovation in Health Management (CIHM) decided to run an Inquiry into fit-for-purpose governance. The CIHM network (comprising a wide range of NHS staff, academics and change consultants) identified a series of questions crucial to the understanding of how to increase the impact of governance in the NHS. This report presents the findings of an investigation made possible and supported by the voluntary contribution of many NHS personnel. Below we provide examples of some of the compelling questions that have stimulated our interest and willingness to undertake the research:

- What is the impact of governance on changing behaviours in a public system, and on the effectiveness of the organisation?
- How can local accountability and local ownership be generated within the NHS?
- Fit-for-purpose design – what structures (if any in particular) work?
- How can governance create alignment across the whole organisation?
- On whose behalf is the board working?
- What type of value does the board offer?

The inquiry team has grouped these questions into two distinctive but related main areas: firstly, an overview and investigation of the impact of governance principles and arrangements on the NHS; and, secondly, an in-depth scrutiny of how of NHS trust boards can contribute to the effectiveness of the system as a whole.

Governance is the set of processes and procedures that ensure an organisation does the right thing. Within the public sector, governance within the organisation has progressively replaced direction from the centre, and processes based on partnership and co-ordination - ‘joined-up’ forms of governance (Martin et al., 2009) - have taken the place of top down approaches (Exworthy and Powell, 2004). At policy maker level, governance is seen as the way to modernise the health service, as highlighted by the Department of Health in its report ‘Governing the NHS’ (2003). At organisational level, the concept of governance is strictly intertwined with the role and functions of the board of directors.
The NHS is a complex beast and it should not come as a surprise that the opinions we have canvassed are diverse (Morrell, 2006).

In the last 20 years the pace of change in the NHS has accelerated and, as a result, the importance of NHS trust boards has grown exponentially. Against this background, our findings offer real insights into how boards operate, the challenges they face and how they can improve. This inquiry is a starting point for boards and policy makers.

The report is structured as follows. This brief introduction follows an executive summary where the main findings are highlighted. Subsequently, a concise review of the extant literature is presented. The methodology section shows how we carried out the Inquiry and analysed the data. The two main sections on governance principles within the NHS and boards of directors’ roles and activity are presented, as well as some practical advice on development.

Effective NHS boards will take the following lessons from the literature:
- Their purpose is to deliver public value
- Clear boundaries are required in terms of purpose and expectations
- Delivering public value requires a higher level of connection between stakeholders
- A network of relationships is required for governance
- Boards need to set the conditions for innovation and improvement
- Boards should stimulate cooperation and enable collaborative decision-making throughout the organisation.
- Board members need political skills in order to make contested decisions
- The culture of the NHS reinforces an ‘expert model’ of management, and there is a pattern of managing in crisis
- Trust and challenge are both critical in board member relationships
- Boards need to work well for the short term and the long term

Private sector boards know what they are there for and whose interests they must protect and pursue. Protecting shareholders’ dividends and ensuring that financial targets are met are simple conceptual goals.

In contrast, public sector boards have to deal with a less defined concept of ownership and the considerably more challenging idea of creating public value through their decision making. The board in the public sector is there to ensure public value is delivered, and therefore needs assurance that the management processes are fit to fulfil the board’s stated goals/purpose. This assurance will include confidence in risk management and innovation; in clinical and managerial practice.

One way of addressing this lack of a concrete bottom line to act as a motivator is to use the work of Professor Mark Moore of the Harvard Kennedy School who, in his 1995 book ‘Creating Public Value’, suggests that public value is created by public managers if they integrate:
- substantive judgments of what is valuable and effective;
- a diagnosis of political expectations; and
- hard-headed calculations of what is operationally feasible (Moore, 1995 p 22).

This makes clear the complex nature of ‘value’ in the public sector, where creating value is an integral part of the political and managerial process.
What is the context for NHS boards? Boards in Public organisations

Comparisons with the corporate sector

Members of public sector boards have a different and potentially more meaningful role than those in the private sector (Cahan et al., 2005) as they cannot count on the aid and direction of shareholders/owners in monitoring and controlling their managers. For a shareholder, there is a clear correlation between the money he or she invests and the money he or she receives in dividends as a result of the company’s performance. However, the taxpayer does not have any control (apart from at the ballot box) over where his or her taxes are spent, and therefore has a much more distant relationship with the details of service provision. Hence, the exercise of control over managers is a greater part of the role of public board members than those in the private sector (Breckley et al., 2003). Some NHS foundation trusts are experimenting with using members of the community to give direction to the board in a shareholder/owner role. However, these NHS boards still need to play a greater directive role than those in private corporations.

The absence of shareholders should not, however, be taken as a sign of complete freedom. Being funded by central government, boards have to periodically account for and deal with the constraints and limitations of the political system (Rainey and Chun, 2005). Furthermore, the trustee dimension of health sector organisations introduces another layer of responsibility on these public boards (Dobel, 2005). As a trustee, boards need to consider the long-term consequences of their decisions, as well as the short-term. This requires a greater strategic contribution from public sector executives and non-executives in contrast to a private sector board focused on a more streamlined, generally financial, set of objectives.

The increasing role of boards in the public sector (Benzer and Frey, 2007; Comforth, 2003; Rhodes, 1999) has been a clear goal of policy makers in steering the British health service towards the so-called ‘third way’. In the UK, this has involved the decentralisation of decision making. This has involved the decentralisation of decision making (Martin et al., 2009) and the notion of the rights and responsibilities of the patient (Malby and Plaimg, 2006). The underlying assumption has been that services delivered more closely to the patient can be more effective and responsive as well as more likely to encourage individuals to make improvements to their own health, thus contributing to greater public health.

Government efforts to design public services that incorporate local and dispersed ownership have emphasised the idea of “co-production”. Co-production can provide fit-for-purpose services to overcome some of the barriers in the NHS, notably the over-reliance on expert models. Further, the principle of co-production increases the accountability of the service provider to the public and, on a more general scale, the accountability of the whole system to the wider population (Malby and Plaimg, 2006). This represents a philosophical change in policy making, away from standardised services towards co-production and partnerships between the different parts of the complex network.

Stakeholder engagement

Another key aspect of public sector organisations is the explicit responsibility towards different stakeholder groups. Boward and Lafléfier (2003) define good public governance as the adoption of a set of formal and informal rules and processes that enable stakeholders to influence policy decisions, at political and operational level.

Full stakeholder participation enhances the democratic legitimacy of the board in a political system (Slater, 2006). As a consequence, boards of directors are forced to rely on and cultivate an extended network of relationships with stakeholders beyond those in the private sector.

The public value concept

Going beyond the ‘New Public Management’ mantra of public choice, this encompassing concept places the emphasis on two dimensions (Benington, 2008):

- What the public values
- What adds value to the public sphere

Recent policy design has focused on the creation of public value coupled with ensuring the confidence of taxpayers (Barber 2006; Gilbert 2005) by improving the quality of the services provided through the so-called ‘enabling state.’ This has involved the decentralisation of decision making (Martin et al., 2009) and the notion of the rights and responsibilities of the patient (Malby and Plaimg, 2006). The underlying assumption has been that services delivered more closely to the patient can be more effective and responsive as well as more likely to encourage individuals to make improvements to their own health, thus contributing to greater public health.

Government efforts to design public services that incorporate local and dispersed ownership have emphasised the idea of ‘co-production’. Co-production can provide fit-for-purpose services to overcome some of the barriers in the NHS, notably the over-reliance on the expert model (discussed later). The principle of co-production increases the accountability of the service provider to the public and, on a more general scale, the accountability of the whole system to the wider population (Malby and Plaimg, 2006). This represents a philosophical change in policy making, away from standardised services towards co-production and partnerships between the different parts of the complex network.

Public value as a set of ideas also fully recognises the central role of politicians and the political process both in the definition of value and the design and delivery of value.

The board role in public value

How is this relevant for public sector boards? Put simply, with more in depth explanation later, they have two major roles. Firstly, as the centre of a network of stakeholders, they play a vital role in defining and clarifying what the public values as they make tough decisions about resources. Secondly, they are accountable for the performance of their organisations and the outcomes of service delivery.

Public organisations are forced to work with a limited amount of resources (Moore, 1995). And recent years have seen an increased demand for efficiency (Wiring and Weinere, 2005). The decisions of the board are vital in terms of adopting and applying effective governance principles and arrangement (Hodges et al., 1996). Boards have to take into consideration:

- The multiplicity and diversity of management objectives, designed to reassure stakeholders that there is adequate accountability.
- Improvement of service quality and the achievement of local performance targets.
- Nurturing innovation and partnerships as the means to achieve improvements in the face of financial cutbacks.

A large part of the role of public executives is implementing government policy (Osborne, 2007). They are accountable for their decisions on how public money is spent, as well as the quality of the service. In addition they are at the centre of a vast network which influences the formulation and implementation of policies. The relationship between the parts of the system represents a core feature of the governance mechanisms (Bovaird, 2006; Techer et al., 2006).

If the theory of public value is to be fully embraced, the board needs to transfer the consequences and implications into daily activity and align the purpose and goals of the organisation accordingly. This is easier said than done, but we hope to provide valuable suggestions supported by our findings.
Particular challenges for NHS boards

Politics within the NHS and communities

Douglas and Ammeter (2004) emphasise that NHS organisations operate in an environment characterised by a complex network of multiple interests and goals. Mediating these potentially conflicting elements is one of the most important factors in successful governance and is a thread running through many of the challenges faced by the NHS. NHS board members require strong political skills in such a challenging context (Ferlie et al., 2003).

The decentralisation of health care has raised expectations about public engagement across the NHS. Managing the complex set of interactions that result represents the political aspect of governance in the NHS (Harley and Brannick, 2006). Crick (1993) explains that the goal of this political activity is to balance out the conflicting interests and values of the different stakeholders to create a truly common purpose.

National politics and the NHS

The NHS is a major part of government expenditure and touches upon the lives of the whole population. It is therefore inevitable that the work of NHS boards will be scrutinised by the government. This can be seen through the government’s focus on the implementation and monitoring of performance management (Hood, 2007). The star rating system, based on a balanced scorecard approach, has received wide publicity since its introduction to the NHS in 2001 (Bevan and Hood, 2006), mainly because of its role in acculturating accountability for managers. Underperforming individuals may be singled out to the point of losing their jobs, (Smith, 2002) or will simply be subjected to external scrutiny (Bevan and Hood, 2006).

These government initiatives have in part been seen as a way of reducing the power of doctors on their jobs, (Smith, 2002) or will simply be subjected to external scrutiny (Ferlie et al., 2003).

To drive down costs and increase efficiency (Dealink, 2002; Le Grand et al., 1998) the emphasis is now on patient choice and the provision of alternatives to patients (Dent, 2006). The principle at work is of ‘market governance’, where the final user is best equipped to judge and choose the health care he/ she requires (Greener and Powell, 2008). This new ‘commissioning environment’ challenges NHS boards to ‘manage the system’ through governance. In a full market, consumer choice (where and how much to pay) forms the basis of regulation by ‘exit’ (organisation closure), but in the constrained environment of the NHS, the ‘voice’ of users is through the political process and boards must enable that process.

Addiction to crisis

The complexity of working in a highly politicised environment, with diffuse accountability between the centre and local organisations, and a rapid pace of change contributes to the view that the NHS operates in a “culture of panic”. Pettigrew et al. (2002) suggest that managers cannot distinguish between what is urgent (requires immediate attention) from what is important (central but deferrable). However, despite the negative connotation of ‘panic’ and ‘crisis’ Mueller et al. (2004) propose that they can help managers achieve positive changes as they force stakeholders to come together and make decisions. Grint (2005) classifies such problems as ‘critical’ problems.

Complex issues and wicked problems

Complex issues have been classified as ‘wicked problems’ (in contrast to ‘tame’ ones) because of the difficulty in defining their characteristics and root causes and hence the problem of clearly understanding their nature (Rittel and Webber, 1973). They are likely to cut across organisational, operational and professional boundaries. They need to be tackled by more than one person. They are not likely to be solved through ‘best possible’ solutions and thus might easily reappear in the long run (Williams, 2002). Such problems also involve non-linearity and the unpredictability of interconnected relationships between events and agents. As such, partnership and co-operation need to take precedence over rigid professionalism and inflexibility (Williams, 2002). Clarke and Stewart (1997) suggest that wicked issues require a holistic and encompassing approach, the ability to take decisions beyond sometimes blurred boundaries and to engage a whole different range of agents. Grint (2005) also adds a third category of ‘critical’ problems which may need solutions that previously were considered unacceptable. These enable directive behaviour in a similar fashion to ‘tame’ issues, but care must be exercised not to confuse ‘critical’ and ‘wicked’ problems.

The relevance of wicked problems has increased in parallel with the change in governance of the NHS the old agenda of safety and accountability is essentially a set of ‘tame’ issues. The NHS has a documented history of achieving results by applying project management principles and centralising authority and control (Bate and Robert, 2002) and these ‘tame’ issues fitted well into that approach. The new agenda of adaptability and innovation required to produce more ‘public value’ is more complex, involving many more interconnected events and stakeholders – these are ‘wicked problems’ which require a more organic approach, crossing organisational boundaries and building co- operative behaviour.
The expert model

The official narrative of the evolution of governance in the NHS is one of a progressive introduction of the market-based approach in the 1980s and 1990s, bolstered by a ‘third way’ concentration on ‘what works’ in the period since (Davies et al., 2000). However, many commentators note that from its inception, the NHS has been dependent on the medical profession for the daily running of the whole system (Greener and Powell, 2008). Doctors had to be lured into the new system with the promise of money and other sweeteners, (Lewis, 1998; Rintala, 2003) including professional autonomy and substantial control over the governance of the health care system – often characterised as the ‘Expert Model.’

However, the pattern of reforms from the 1980s onwards is of government attempts to decrease the power of doctors (Harrison, 1999). For instance, Ferlie et al. (1996) highlight the reinforcement of internal lines of reporting and the reduction in the number of clinicians on management boards. This is thought to have resulted in a shift in the balance of power between managers and clinicians (Harrison, 1999). However, many of these interventions have been counterproductive and reinforced the barriers to effective co-operation (Currie and Subramoniam, 2006).

While the formal structure is clearly a ‘non expert model’ governance, with boards dominated by non-clinicians, the old ‘expert model’ still has a remarkable impact on the activity of many boards. Board work is often marred by the same issues that dog the wider manager-clinician relationship. Board dialogue is often constrained by the unwillingness of non-medics to challenge medics but doctors are at the same time believed to be incapable of understanding the challenges of effectively managing NHS trusts (Hope et al., 2004).

The clinician – manager roles and relationship

NHS managers in their current incarnation were created in the 1980s, in an attempt to gain control from a dominant medical profession (Greener, 2008). The government wanted to give managers more control and decision-making power and enhance their ability to drive efficiency in terms of both cost and service improvement (Petitrew et al., 1992). The government’s aim has been undermined by the clash between managers and clinicians, with the latter successfully blunting the impact of many changes (Klein, 2001).

A new strategy was implemented in the 1990s, with the introduction of the internal market. Purchasers were separated from providers to open up competition within the NHS. In addition, the introduction of a system of clinical groups led by clinical professionals with responsibility for the budget was aimed at improving internal management by using professionals to manage other professionals (Higgott, 1996). This was hoped to improve the alignment between the conflicting interests of managers and clinicians (Harrison and Pollitt, 1994). However, it was in part interpreted as a further attempt to loosen the grip of the medical profession and created a more receptive environment for change (Ham, 2000).

Nonetheless, clinician power remained strong and proposed modifications in their contractual agreements were substantially watered down (Higgott, 1997; West, 1998). The scale of reform was limited in part because clinicians accepted managerial roles more as a political response than out of dedication to the government’s vision for hospital organisation. At the same time, doubts were expressed whether clinicians possessed or had the ability to develop the necessary managerial skills (i.e. financial literacy) without any experience, training and a commitment to the new vision of their role (Weightman, 1996, Ferlie et al., 1996).

The Darzi report (2008) defined a new government commitment to address the engagement of clinicians in management as part of an agenda of ‘enabling NHS staff to lead and manage the organisations in which they work’. The report redefines the role of the clinician adding ‘partner’ and ‘leader’ elements to the traditional ‘practitioner’ role. The partner role calls on doctors to be involved in “the appropriate stewardship and management of finite healthcare resources” whilst the leader role states that clinicians are expected to show leadership and in places take on formal management positions. The report promises changes to the financial incentives to encourage this behaviour. To support doctors who take on these new roles, the report recommends a national standard for leadership education for clinicians and further programmes to develop management skills. It is still too early to judge the impact of these reforms, but they do attempt to address the criticisms raised in the past.

Implications of the clinician-manager relationship at board level

Boards are not seen as neutral ‘governors’ of an organisation, being largely composed of non-clinicians, and doctors tend to identify them with ‘management’. Board members therefore must take account of the tensions in the clinician-manager relationship in governing the organisation.

In 2007, the CII-HD undertook a national inquiry into the effect of the clinician-manager relationship on the performance of NHS organisations (Kirkpatrick et al., 2007). We found tensions with performance management systems used to reinforce management power rather than support partnership between management and clinicians, the overall system of professional education and socialisation; and perverse incentives that have discouraged clinicians from devoting time, resources and efforts to managing the NHS. Above all Kirkpatrick et al. (2007) worryingly describe an overwhelming impression that NHS senior managers and leaders believe improving relationships and understanding between two roles is risky approach and hence refuse to commit to these activities.

Boards are charged with the difficult task of making the relationship work within each individual trust. The results of the 2007 inquiry suggest that they should concentrate on creating productive relationships that are characterised by collaborative forms of leadership and shared decision making. In cases where this focus has been maintained, it appears to deliver improved alignment of decisions across different organisational functions, greater commitment and willingness to engage, and greater capacity to deliver innovation.

Boards, experts and innovation

A key priority for boards in the current climate is their role in supporting innovation, as major source of service improvement in straitened financial times. This is in line with a move from a mechanical focus on financial targets to a more dynamic approach based on the interconnections and relations of internal and external networks (Currie et al., 2007). Central to this is the view that service improvement can be achieved by actively supporting processes of learning and the management of knowledge across institutional and professional boundaries (Bate and Robert, 2002; Currie and Subramoniam, 2006; Finger and Birgim, 1999).

This issue also highlights the practicalities of dealing with the legacy of the ‘expert model’ in the NHS. It is widely accepted that the health sector is fragmented and there is a clear need to encourage the crossing of organisational and professional boundaries (Mejzioom et al., 2004). These professional divisions have long been singled out as a substantial barrier to knowledge sharing and the dissemination of innovation in the health care sector. An influential study looking at innovative practice, Ferlie et al. (2005) show that cognitive and social boundaries among professionals reinforce their inclination towards working within institutionalised communities of experts. Professional groups, therefore, bear considerable responsibility for creating barriers to the spread of innovation beyond the profession or the institution. However the informal ties, common knowledge base and research culture within professional groups facilitates interactions and new knowledge sharing. To avoid reinforcing this ‘stickiness’ of knowledge (Brown and Duguid, 2001) an open environment which welcomes outsiders needs to be established (Ferlie et al., 2005).

In our opinion, boards can play a vital role in all this. However, to do so they need to embrace the principles dictated by the network governance and/or collaborative public management perspectives. The next section will examine the solutions found in the literature in more depth.
What the literature tells us about possible solutions

The debate is wide open on what really works in terms of NHS governance. Exworthy et al. (1999) have defined the current governance system as “quasi-market, quasi-network and quasi-hierarchy”, underlining the fact that reforms and new guidelines have rarely achieved their intended outcomes (Morrell, 2006). Almost ten years on from the seminal contribution of the mentioned article, Martin et al. (2009: p. 2) reached a similar conclusion, that there is still a “well documented tension between hierarchies, markets and networks”. This inner tension has been fuelled by a trend towards collective forms of managing health care provision through private sector type markets, coupled with an emphasis on top-down performance management and the proliferation of regulatory bodies (Currie and Suhomlinova, 2006; Ferlie et al., 2003; and Martin et al., 2009). Four important strands show through in the literature about successful boards.

Legitimacy

As discussed above, government strategy has clearly taken a direction towards emphasising the importance of decentralisation and devolving responsibilities to trusts (Greener and Powell, 2008; Hunter, 2005). However, to retain the support of the community and other stakeholders when taking contested decisions, boards must develop legitimacy with them, as historically the NHS has not worked in this way. Accountability is no longer only associated with individual responsibility, or with reference to central authority targets, it must be representative of local needs (Pratchett, 2004). The notion of accountability in the NHS now covers a substantially different (and broader) area than in other sectors.

Sustainability

The shift in policy from a focus on financial and safety targets (Barber, 2006) to a public value based on innovation (Currie et al., 2007) co-production and partnership (Moore, 1995) is real, but the pressure to conform to central targets remains (Greener, 2005). Any attempts to restructure the organisation around innovation must be balanced with a commitment to meeting key indicators; otherwise the government may reverse the change (Greener and Powell, 2008) either by removing the board or introducing a ‘humansound team’.

Partnership

As outlined above, the new model of public governance is centred on the idea of networks or collaborative forms of governance. These are perceived as superior because they encourage cooperative behaviour based on trust and diplomacy (Rhodes, 1997), as well as creating the right conditions for the generation of shared values and norms (Provan and Kenis, 2008; Rhodes, 2007). The policy design has been strongly built on the idea of concerted decision making through the involvement of multiple stakeholders (Meier and O'Toole, 2005; McGuinn, 2006; Ansell and Gash, 2008). What is clear, however, is that this partnership “must” be achieved even when the pace of change in the system does not seem to allow for it (McMurray, 2007). In addition, the “pandemic” wave of reforms has taken its toll on the ability of board members to establish durable partnership agreements (Dunkley, 1995; McMurray, 2007).

Multiple perspectives

The relationship between executives and non-executives is crucial to the success of the board, and for this reason there should be a fine balance between cooperation and confrontation (Sugarman, 2007). However, building a board environment where trust and challenge are safe is not an easy task. It is one thing to say that non-executives should effectively scrutinise executives’ actions, it is quite another to create the conditions that enable them to do this (Bevington et al., 2005).

It is also imperative for the board to be strategically focused and outward looking (Carver, 2001; McNulty and Pettigrew, 1999). This is crucial despite the pressure of meeting short-term targets and dealing with political expectations – a successful board manages to look ahead and give direction to its organisation (Farrell, 2005). Central government has pushed for giving director roles to people from the private sector on the assumption that they have a better idea of what is expected and can therefore give better direction (Mueller et al., 2003).

Methodology

The design

The research design of the inquiry was built around two main research questions:

- How can ‘better’ governance help health care organisations deliver overall NHS objectives?
- How can NHS boards of directors improve their performance and become more effective?

The field work was undertaken with two independent but clearly connected aims.

The research method was modelled around the co-operative inquiry mode. This is based on the idea that, through a group-based approach, everyone engaged in the research project acts as co-researchers and co-subjects (Heron, 1996). The aim is that every participant is given an opportunity to define the question to be answered, the perspectives and ideas applied and the conclusions drawn. Everyone is invited to contribute to the formulation of ideas and to take part in the research process (Reagan, 1999). In addition, the interpretative process entails an ‘intentional interplay between reflection and sensemaking on the one hand, and experience and action on the other’ (Heron and Reason, 2001 p. 179). Finally, co-operative inquiry allows for harmonious collaboration of the research team (for example academics, consultants, industry experts) and a research project concentrated on more than one organisation.

We used a range of qualitative methods to understand the dynamics of NHS governance at both organisational and board level. The project was carried out between January and April 2008. We used diverse units of analysis and multiple data to improve comprehension of the interdependence between organisational dimensions (Pettigrew, 1990). Rather than use a grounded theory strategy, we wanted to create a schematic interpretative structure on the basis of extant literature (Ferlie et al., 2005; Langley, 1999). We selected a dynamic interpretative method of analysis (Lee, 1999) as a way of understanding the behaviour of the organisations. Specifically, process research is well suited to building an understanding of how organisations develop over time (Pettigrew, 1997). It allows the building of a chronology of events as well as the generation of insight and theoretical concepts closely related to the data (Golden-Biddle and Locke, 1997).

The structure of the inquiry

Following this design, the methodology involved three workshops. Each workshop comprised focus groups, whole participants’ discussions and making sense of the activities performed. The inquiry team held five formal meetings, coupled with informal contacts between team members. Finally feedback was sought from all the participants on the results of the inquiry.

The first workshop brought together 27 NHS board members and governance professionals (12 executive directors, nine non executive directors and six senior executives) with a mixed managerial/ professional background. It was divided into two distinct parts: firstly, a storytelling session about examples of effective governance involving small groups of participants, where the participants had to assume in turn the role of interviewee, interviewer and moderator. This session members of the inquiry team acted as observers. Secondly we had a collective session where the inquiry team led an activity about common themes and lessons from the stories previously told. These stories represented the valuable first information on organisational case studies, which moulded the other research method.

The second workshop was directed at engaging with the “shapers” of governance from within the NHS (policy makers, people and organisations that influence policy and policy implementation), and hence involved members of the Department of Health, strategic health authorities, various commissions and a few independent consultants (for a total of 13 organisations and 17 informants – three executive directors, six non executive directors and eight senior executives). In this workshop, the preliminary findings of the initial session were reported and discussed, and then the participants were asked to form small groups and interrogate each other on their ideas and experiences of effective governance. Once again, the inquiry team led a plenary sensemaking session of the overall activity.

The third workshop was then held as a unified session where board members and governance professionals met and discussed the first two sessions with the NHS governance shapers. In addition, between workshops, the inquiry team repeatedly invited comments and feedback from participants. No formal interviews were conducted, but informal discussions took place throughout the workshops. We hoped this would encourage free flowing recollection of data and experiences from the participants.
Inquiry participants

The inquiry investigated 13 NHS organisations, mainly concentrated in the north east of England: two mental health trusts, one mental health teaching foundation trust, one ambulance service trust, two teaching hospital foundation trusts, five primary care trusts and two NHS trusts. The trusts’ boards comprised 178 members (95 executive directors and 83 non executive directors), with a median size of 15 members (eight executive directors and seven non executive directors). The active participants therefore represented 12 per cent of the total board population. However, the inclusion of six senior executives who have a ‘director of governance’ role increases the knowledge base and reliability of the sub sample. Despite the relatively limited geographical coverage, we believe that the sample adequately represents the overall population of England and Wales.

Following Eisenhardt (1989), the selection of the organisations was both opportunistic (location, existing contacts with participants and familiarity among the inquiry team with the trusts) and theoretical (the trusts represented a moderate variety of organisations within the health care sector and their governance arrangements had all undergone change). Crucially, this was confirmed by the shapers who agreed that the trusts in the sample were representative. It was the inquiry team’s explicit intention to look at organisations working in the same environment and with recognisable similarities in their scope but, at the same time, with differences in terms of goals, resources and hierarchical position in the NHS. The research design was thus framed with the idea of uncovering similarities (or not) in their governance.

To enhance the significance of the inquiry and the validity of the findings, the participants were selected according to their job role, experience and familiarity with governance. All the workshops were tape recorded and then transcribed. A list of the participants is included in this report but each contribution is anonymous. The meetings and discussions of the inquiry team were all summarised and circulated amongst the members for further comments. The data collection phase was then followed by coding and categorisation of the material with Nvivo software. The coding was carried out by one member of the inquiry team and validated through individual analysis and collective discussions within the team. The first order coding led to a second order collective coding to uncover any common themes (Bryman and Burgess, 1994; Silverman, 1993). Each member of the research team made extensive use of handwritten notes which were examined at the formal meetings to develop a richer understanding of the data (Eisenhardt, 1989).

The composition of the inquiry team was also heterogeneous: an industry expert who acted as team leader and critical friend in the workshops, an independent consultant with wide experience in the public sector, a former chair of an NHS trust and health quango, a project manager with considerable experience of public sector boards, an academic with broad knowledge of governance matters, and an academic researcher. We hoped such a diverse group would lead to a broad interpretation and balanced analysis of the data, thus facilitating triangulation of the data (Eisenhardt, 1989).

Case study approach

We used a multiple case study approach to give us different perspectives on the dynamics, processes and outcomes of boards’ settings (Eisenhardt, 1989; Yin, 1994). Thirteen case studies were written up from the stories told in the first workshop and informal discussions with the participants. The case studies were summarised and then cross analysed within the inquiry team and then sent to the respective participants’ organisations for validation (Bloor, 1997). The case study data was then reduced to cross tabular tables as suggested by Eisenhardt (1989) to increase the critical analysis of the cases. Following Denis et al. (2001), we have used the multiple case study approach to develop a more comprehensive theoretical framework by building on the insights of one case to another. The “replication logic” has been achieved through the iterative process of deduction and induction as theoretical propositions were generated and tested through the consequential analysis of the cases (Eisenhardt, 1989; Yin, 1994).

Validity

We do not claim absolute generalisation or statistical reliance of the research findings. Nonetheless, several factors make us confident of the validity of our approach: the considerable experience and knowledge of the participants, the accumulated expertise within the inquiry team and the research design (Eisenhardt, 1989; Yin, 1994). The main goal was to enrich the understanding of how governance principles and arrangements impact on NHS organisations (Langley, 1999). We have also sought to enhance the richness of the secondary data (trusts’ internal reports, board minutes, newspapers articles, government public rankings) and the adoption of a complex iterative process of analysis which has simultaneously engaged participants and inquirers. The interpretation of the data was deductive in terms of the replication of ideas from extant literature but also inductive as themes emerged from the empirical results and were validated by the participants (Yin, 1994). The consistency of the research findings was supported by matching key themes and topics from the existing body of theory with those emerging from this research. The constant interaction was aimed at reducing researchers’ bias (Miles and Huberman, 1994).
The inquiry findings part 1: Excellent governance and the NHS

In our view the design of governance through NHS boards offers the potential for excellent governance. At the same time, it is no secret that many NHS board members and senior managers are unsure about what governance contributes to the health service:

"I actually find it quite difficult to focus on a topic such as effective governance, and that is the result of being constantly in massive change. It has been many years now that we have constantly gone through structural changes"

NHS EXECUTIVE DIRECTOR.

"Actually I'm struggling to find a good example of governance in my experience"

NHS CHIEF EXECUTIVE.

However, whilst the design may be fraught with tensions, it still enables boards to do good work. We found that boards are not making the most of what is within their power to do. Their frustrations, directed externally, are actually a product of their own choices. Effective governance can be achieved, but it requires great commitment and strong focus of board directors.

1. What is the difference between governance and management?
   "We're trying to move away from management into proper governance, but that is very difficult, especially when your background is set on management principles and activities"

SHAPER.

Governance is the point where the external political process gets translated into managerial behaviour: that is, its strategy. Strategy requires making sense of the context, working out the choices and what relationships are needed to deliver these choices (rarely can an NHS trust work in isolation), determine what they can be accountable for, negotiating that with owners, developing adaptive capacity within that strategy, providing some parameters in terms of 'how' (these relate to the organisation's values and the wider values and objectives of the NHS) and then handing that over to managers to determine what needs to happen on the ground. Management then demonstrates how it is delivering the strategy in line with the board's vision.

"For me governance – it's about the ends and not just about the means through which the answers are achieved... We need to specify the requisites and conditions of the organisation and the context of the statute. We need an outward looking focus"

SHAPER.

What we have found, however, suggests that many senior managers seem puzzled by the presence of different governance models within the NHS. Consequently, people involved in governance are not clear about what model works better (if any) and hence what model to adopt in their organisation. This appears to be a result of a central government emphasis on the spread of best practice which has led to confusing rather than inspiring senior managers and board members.

"There is too much ambiguity in the current system of governance to provide an effective service to the public... I actually think that too much ambiguity generates toxicity and you can easily see that in some boards"

SHAPER.

In the private sector, the “one-size-fits-all” approach has long been criticised (see Daly et al., 2003) on the grounds that every organisation is different and the automatic and mechanistic application of governance principles does more harm than good. Ideas about governance can be shared between organisations but they must be tailored to each organisation.

“For me good governance is about having a sufficiently good system that gives you the opportunity to be independent, to not operate under constant pressure and direction from the central government. So, I can honestly say that because of this good governance, and the board in first place, we have been able to make a difference for our patients, to take effective care of their needs”

NHS CHAIR.
2. How does governance help the NHS achieve its objectives?

The role of the board is to arbitrate value. It must decide where attention and resources should be focused. The board works strategically incontestable space – through dialogue. To do this it needs to be able to:
- See the deeper issues
- Work with multiple and diverse views
- Challenge ‘what is’ – how things work here, what actually takes place.
- Work non-judgementally with ‘what is’.

“Good governance is making sure that people know what to expect, what they will see. It is about meeting their expectations. It is also about providing the right information, not just the standard one. It is about understanding the right dynamics, the way to express different professions and different directorates within complexity of relationships. The tensions between Board members are faced with an incredible internal management. Outside the organisation, and too much time on – it is making judgements about public resources. The context. The majority of the board’s work is political.

Governance is an inherently political activity – making choices about public resources. Governance is also about balancing the many interests involved in the delivery of public health, which is not always achieved.

“Frequently you have opposing conflicts between the demand of the government, the customer of the health care, and the needs of the consumer of the health care.”

The Political Context

If only the politicians weren’t involved! At all levels the unifying view is that politics and politicians are the problem. Governance in the NHS would be simple if it wasn’t operating in a political context. The boards talked as if they were victims of the ‘system’. The modus operandi was to try to avoid/ignore the political context. The majority of the board’s work is political – it is making judgements about public resources. Boards spend nowhere near enough time looking outside the organisation, and too much time on internal management.

Board members are faced with an incredible complexity of relationships. The tensions between different professions and different directorates within their own trust are difficult enough but are made even more so when they are taken into a political area.

How do you explain internal tensions to an external audience? The internal context is too hard to explain and for boards the political context feels messy and ‘overcomplicates’ already difficult work. If the board is confident about working with diverse perspectives and making decisions, then it will be working in the political dimension.

In the most recent form of public governance, central authorities are still actively participating in policy but a much larger contribution is expected (and supported) by multiple actors operating at different levels within the system (Andresani and Ferlie, 2006). Farrell (2005) suggests that public service reforms have seen a move from government (featuring a bureaucratic system dominated by central authorities) to governance (where key strategic decisions are taken at local level according to central policies). As a result there has been less direct political involvement from the centre and more fragmentation of service delivery systems. Nonetheless, public management is still characterised by the need to gain political support and manage a diverse range of interests internally and externally. Public managers are bound to depend on political authorities for the approval of their activities and funding (Rainey and Chui, 2005).

In essence, the political context is a ‘given’. If politicians aren’t the final arbiter of value who is? Is it the board? So if not politics then what? Who will decide value? Who will decide what gets rationed?

Boards that are successful politically rely on dialogue and cooperation amongst parties to go beyond existing differences and achieve a wider range of organisational outcomes (Harley and Branicki, 2006). The effective delivery of health care requires boards to politically engage in ever changing environmental settings and, especially, to be successful in gauging how politicians relate to their organisation.

This requires boards to recognise that their work is political and not managerial. This in turn requires them to be open to public scrutiny. Board decisions need to be auditable – and need to ‘add up’.

Decisions need to be ‘legitimate’.

“Personally I think that governance is about transmitting ownership and direction into organisational performance…Boards have to take responsibility for what they are supposed to do and for what they are actually delivering.”

Co-production

This leads into the realms of co-production, where communities and individuals play an active part in both commissioning decisions and treatment and care choices. Most health services are co-produced in that it is the combination of the expertise of the professionals, and the responsive behaviour of the ‘patient’ that produces results.

The importance of networks within the public service realm has been highlighted not only at decision making level but also, and perhaps more significantly, at the service delivery point, where relationships and ties play a fundamental part (Klijn, 2005).

The NHS is beginning to explore organisational forms that are based on reciprocity and embrace the concept of ownership in foundation trusts. Strategy and service development requires boards to work in partnership with patients and communities. It also requires boards to design services which require obligations from patients and communities – responsibilities that act as access points to care/treatment you can’t get a heart transplant if you carry on drinking is the extreme example of this.

“it is not an exaggeration to say that if you have a very good governance system you can actually achieve the patients’ care objectives that are set centrally.”

Start from ‘what is’

So part of ‘what is’ is the political context in which the board operates. Our findings suggest that public enterprises are rather different from private businesses and face different challenges (see Clatworthy et al., 2000, Farrell, 2005). Accordingly, the Inquiry participants appeared to share the view that there must be more clarity on what is distinctive about public organisations. So, a “must” for every NHS board entails making sure that people from a business background understand the differences in public management.

The other ‘what is’ is the patient’s, carer’s and community’s experience of the NHS. Boards reported very varied activity on really understanding the user’s experience.

“The difference between the NHS and the private customer service organisations is that we still do not have at the centre of our agenda the patient. We have it, perhaps, at the level of the Department of Health but not at the level of the board.”

If the ultimate purpose of an NHS organisation is improving the health of the population (our business is health), it therefore seems obvious that we need to understand what the primary purpose of an NHS organisation is. At the same time boards need to take into account the gap (which may never be entirely filled) between what we would like the NHS to deliver and what it can actually deliver. Boards need to be entirely clear what their organisational goals are and their discussions and decision making should be constantly aligned with those purposes.

“The rigour in the decision making process actually generates a better understanding of the health care needs and what the organisation is trying to achieve, which helps to understand different areas and which might also broaden the horizons of the board itself”

“Good governance allows raising awareness about the whole organisation, its structure and its means. People in the organisation know what they are part of, know what the organisation is about... Good governance is about everyone in the organisation knowing what we’re here to do, and what are the responsibilities and consequences of decisions and behaviours”
Balancing national and local objectives – creating alignment

The two main principles behind the ‘decentralisation’ of the health service are that decisions taken locally are better for patients and that the engagement of local communities improves the patient experience (Allen, 2006). The aim has been to make the NHS more open to scrutiny and invite the public to express their views. However, central monitoring and control and other financial, managerial and operational tools give government the opportunity to intervene. Boards add value by making sense of the ever-changing political context and adapting their strategy within that context. They must also influence and shape that context. In the political context needs/requirements can change rapidly – it is dynamic. If the board is clear about its organisational capacity, and its long- and short-term imperatives it will be able to adapt its strategy. This requires persistent attention to the ‘up and out’. The board must look outside its organisation as well as ‘down and in’ the organisation. It is not about acting as a messenger for central government, nor as a victim, but about embracing the policy and making choices in relation to the local context.

All recent governments have wanted managers to take more control of running the NHS, but I keep on coming back to the concept that ‘entrepreneurial governance’ would improve the efficiency and effectiveness of the system (Currie and Brown, 2003). Government’s main objective has been to develop power and control locally, giving NHS managers and their organisations greater autonomy, decision-making power and assessment functions (Hoque et al., 2004).

In our workshops the draw of the ‘down and in’ was crowding out the ‘up and out’. This again is choice. Boards choose where to focus their energy. They need to do both. Successful boards are engaged in the policy process as well as the patient’s journey.

Balancing innovation and assurance

There appears to be a tension between doing the ‘assurance’ – risk management or performance management – and innovation (developing relationships, learning and experimentation). Governance can be overwhelmed by assurance work, rather than creating the conditions for innovation, and it’s not clear that boards know how to govern for innovation. Assurance itself is not enough. You also need ambition to create public value – innovation is a requisite.

“I had a look at the old board assurance framework that was in place... They (the previous assurance committee) wrote the risk assurance framework in a very closed environment. It had been done, if you like, in a very isolated way... that for me was a totally inappropriate process, which completely ‘dis-respected’ the appropriate governance process. I wanted to look at organisational engagement, I wanted to look at ownership, I wanted to look at our strategic plan, and I wanted to look at responsibility and accountability.”

NHS EXECUTIVE DIRECTOR TALKING ABOUT THE NEW STRATEGIC PLAN.

Successful sharing of knowledge and innovation clearly depends on an environment where cooperation and involvement are actively encouraged. For this reason, Booth (2003) advocates the integration of knowledge management within the overall business objectives of every organisation, where governance mechanisms enhance the alignment of management practices and professional duties. A supportive organisational culture is necessary for the creation and stimulation of knowledge. Effective clinical governance can be achieved only when all the activities that have an impact on patient care are integrated within a coherent business strategy (Nicolin et al., 2008).

Challenge and difference as a pre-condition

Boards have to deal with a huge range of interests and relationships and the only way they can do this successfully is to encourage different views and perspectives. The board must also be comfortable with challenge. We repeatedly heard that boards do not like working strategically, where challenge is required, and where there is tension and ambiguity. Boards look for ways of managing out ambiguity and distress. Feedback between board members is not a process that many on the board experience or lead.

“For me it has gone from a very bureaucratic process that was not owned by anybody, that was not challenged by anybody, that was given to people, to one where people had been involved in the process and have been actively engaged in the discussion. (Now) there is full accountability, there is full system process, and it’s managed at performance level from the quality and risk group.”

NHS EXECUTIVE DIRECTOR TALKING ABOUT THE NEW STRATEGIC PLAN.

3. What does it take to govern NHS organisations?

(a) Legitimacy

Boards have to make contested decisions. The NHS, as a professionally dominated hierarchy, has no tradition of democratic engagement. Many internal stakeholder groups did not understand or accept the legitimacy of non-executive directors NEDs when they were introduced. Many external stakeholders thought this form of democratic accountability was too limited and unresponsive to local communities, the so-called democratic deficit. The dawn of foundation trust membership and governors addresses this but it requires non-executive directors to ‘authorise’ their legitimacy. In this sense, accountability has been associated with the traditional concept of being individually responsible for one’s actions as well as the more comprehensive view that autonomy should be pursued with reference to rigid control by government agencies (Pratchett, 2004). In essence, the notion of accountability for NHS employees covers a substantially different (and broader) area than in other sectors.

Our participants struggled to come to terms with individual and organisational accountability. Off the record, we have been frequently questioned about accountability (‘accountable to who and for what?’) which drives many NHS staff to feel victims of the system. NHS boards are responsible for making decisions on behalf of the ‘owners’, taking into account the existing tension between individual user and collective ownership. Board members have to take collective responsibility for their decisions and actions.

“For me good governance is sensing the opportunity and having the legitimacy that people and organisations already have.”

SUCCESSFUL DIRECTOR TALKING ABOUT THE NEW STRATEGIC PLAN.

The board is the place where the complexity and dynamism of the ‘authorising environment’ is discussed, mitigated, arbitrated and interpreted into a mandate for the executive team. Board members need to develop their own ‘story’ about their distinctive and legitimate role in delivering public value. Boards must be able to engage with their communities. This is formalised in the case of foundation trusts, in the relationship between the board of directors and their governors and members.

“It is about the life cycle of an organisation. The board that is fit for purpose at one point in the organisational life cycle, would not be fit for purpose at another, and that is true in every sector I have worked in, public or private. If it does not matter… the real important issue is how you maintain dynamism, how much you are dynamic within the board, if the board is self-reflexive, self-critical”

SUCCESSFUL DIRECTOR TALKING ABOUT THE NEW STRATEGIC PLAN.
Modern health and social care is provided by teams of professionals with diverse backgrounds and experience, often from different organisations. The recognition of the importance of the ‘patient/client journey’ has focused attention on collaboration as well as competition. The government is to encourage working in partnership via incentives. Partnership is seen as generating value because it involves people from different organisations working together. The benefits of partnership working are legion, leading to the improvement of health care delivery and a renewed attention to patients’ experiences (McMurray, 2007).

NHS trusts can't deliver excellent services on their own, their business is tied up with other agencies - local authorities, other NHS bodies, the voluntary sector.

"What was critical was not to change the mindset of people, it was to make the whole board aware of what should have been going on and how it should have happened. Part of doing that was to plant a big red flag and tell them that external bodies can provide a big help in terms of suggestions but also open criticism" NHS CHIEF EXECUTIVE.

Effective partnerships have to face up to differences in status and the power to define quality. It means recognising many sorts of expertise including that of patients. This has to replace professional and institutional loyalties with the development of trust between the parties.

The diverse experience and talents of non-executive directors and executives add to the ability of the board to govern well. Diverse views are the source of possibility and adaptation. Going back to the crucial importance of the political role of NHS boards, it is important that boards are made up of non-executive directors from both a business and a political background. That does not mean that board members need to have worked in both areas, but a balance in the make-up of the board should be pursued.

"Sometimes it might be very difficult for the board to understand the business case. In that case the board should work as a forum for different opinions, and evaluate the project in terms of the cash flow produced, in terms of the capital expenditure required. But, actually, there is an enormous value for the rigour that is brought to the decision making process, to look properly at all the alternatives available" NHS NON EXECUTIVE DIRECTOR ON THE VALUE OF CULTIVATING MULTIPLE PERSPECTIVES.

When the board is in control of risk assurance and through the board the rest of the organisation is involved, then the conditions for innovation are created. The innovation paradox is that most innovations are created on the front line and most fail. The board and senior managers have to create the conditions for innovation to flourish, for success to be amplified and for failure to be identified and rooted out early. This means focusing on culture change as well as capability in reading the market (business acumen) and strategy.

"I think what good governance is about is not just fulfilling the minimum, it is not just about doing what is required. It is actually always ... about keeping improving the service, the outcomes, the benefits that we are expected to deliver" NHS EXECUTIVE DIRECTOR.

At the heart of good governance is the balance between assurance and innovation – how much assurance do you need about what? What helps assurance is competence on the basics such as quality and finance.

"We have got a board assurance framework that is owned by the trust board, it's cascaded down and known through the quality risk group, which is accountable and responsible for the quality assurance delivery. It's performance managed through the director executive group month by month, through the group the chief exec holds to account the directors for its delivery" NHS EXECUTIVE DIRECTOR.

"I think what good governance is about is not just fulfilling the minimum, it is not just about doing what is required. It is actually always ... about keeping improving the service, the outcomes, the benefits that we are expected to deliver" SHAPER.

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"I think what good governance is about is not just fulfilling the minimum, it is not just about doing what is required. It is actually always ... about keeping improving the service, the outcomes, the benefits that we are expected to deliver" SHAPER.

Effective partnerships have to face up to differences in status and the power to define quality. It means recognising many sorts of expertise including that of patients. This has to replace professional and institutional loyalties with the development of trust between the parties.
4. How can you design a governance system within the context of a professional organisation?

The distinction between managers and the medical profession at all levels in the NHS has been well documented (Ashburner et al., 1996; Pettigrew et al., 1995). Undoubtedly, professionals still exercise a powerful influence on the system, and their engagement is fundamental in ensuring the success of reforms (Pettigrew et al., 1995). After all, a consistent characteristic of the health sector is the idea that, to be successful, change requires collective rather than individual leadership (Dennis et al., 2001).

We asked board members to tell us about a time when governance ‘worked’ in their eyes. All the examples we received described a crisis: they all pulled together, agreed what to do, drove the solution through and managed to achieve change in the short term. We believe this is a symptom of the dominance of the professional model (which relies on expert knowledge). This leads to boards having difficulties with challenge, with working in contestable space and on behalf of the whole. Clearly, there is not shared clarity (and belief) about the role/power of the governance system. Similarly, the relationship between managers and the medical professionals is still characterised by mistrust and conflict.

“The management-clinician interface is driven by tensions, because the executives tend to be driven by the voice of the customer and the clinicians tend to be driven by the needs of the consumer.”

“There are differences between different professional groups and within professional groups. It is a quite complex organisation to manage.”

The expert model

It is widely accepted in the literature that the health sector is highly fragmented and there is a need to cross organisational and professional boundaries (Meijboom et al., 2004). Health care organisations comprise groups of highly specialised professionals with sector specific values and behaviours (Tagliaventi and Mattarelli, 2006). Not surprisingly, therefore, complex issues are broken down, boxed, and treated separately depending on what and where the potential ‘expert’ is identified.

The NHS management model mirrors the dominant model of professionalism – expertise is valued and rewarded, so directors achieve top management status by being expert in their discipline. However, senior management and board governance requires management and governance on behalf of the whole. Given that the whole is more than the sum of the parts, having expertise in a ‘part’ does not help you work at the level of the whole.

“Governance needs to be able to help people within an interconnected whole, there needs to be outward focus. Far too much attention in governance is inward and downward looking, and short termism prevails. Effectiveness needs to be part of a collaborative action.”

The particular expertise of working corporately of enabling the parts to work within a whole, is not well described in the literature and by participants in the Inquiry. In the workshops we heard repeatedly that solutions to problems required linear / expert approaches and that where individuals needed to work with the messiness of the whole, they struggled to know what to do, and their energy dipped. They found it hard to move from hierarchical behaviours to connecting and influencing behaviours.

This leads to the difficulty of challenge at the board. If authority is invested in models of power through knowledge or expertise (if the basis of membership of the board is that members are experts in their field) then how does that get challenged in the board?

“This is possibly one of the reasons for the inner tension between professionals and managers within boards. Professionals frequently do not know what the structure and role of the boards are about.”

Wicked problems

“I wonder if sometimes the complexity behind the NHS is just an excuse for not delivering good governance.”

The problems faced at board level require collaboration and co-production. Most of them are in fact ‘wicked’ (rather than ‘tame’) problems. Tame problems are those with relatively simple boundaries and root causes, which can be solved by linear approaches. Wicked problems are hard to understand in terms of boundaries and root causes. They involve non-linearity and the unpredictability of interconnected agents and events. They require a more holistic and encompassing approach, with decisions made across various boundaries and by diverse agents.

The NHS has a tendency to put everything in the ‘tame’ box. This ignores the need to work with the complexity of the issue, and the multiple relationships. The wicked stuff requires learning, collaboration, agreement to work together on values, feedback, and experimentation. Because for wicked problems there is no one answer. This requires mature relations in the board – challenge, access to diverse perspectives, time, etc.

“An engagement process (at organisational level) could be quite dramatic to start with and it’s very much about avoiding being bogged down in minor, specific issues and keeping the focus on the overall picture. But it can be very successful in the sense that the trust is forced to take ownership of it and be fully engaged with the different tasks…this process really showed us the will to get away from an issue-based approach and to be more focused on the changes we wanted to introduce in the organisation.”

“The best that we can do is to find a way to reconcile those tensions as opposed to pretend that we are ever going to solve them completely, because I don’t think we ever will.”

Currently boards appear to see dilemmas as tame or crisis (where everyone rolls their sleeves up and acts heroically to rescue the situation). These two situations are where functional expertise is at its best. It plays into the ‘expert’ model – there is a problem, we know how to fix it and it can be fixed hierarchically. It requires someone that knows to tell those that don’t.

The underlying reason people aren’t behaving in a certain way is that they don’t know what to do.

For tame problems there is no need to argue – we can see what the problem is and we know how to fix it. It is the same for crisis situations – you can see the problem and agree it is a problem. In a wicked situation there is no known solution, and even the nature of the problem can be contested (for example, teenage pregnancy). For instance the dilemma of an ageing population – do we concentrate our effort an increasing care for older people, or do we put it into young people so they are able to care for older people?

The dominance of the expert model leads boards into unhelpful ways of seeing and tackling wicked issues.

“We are obsessed with the governance of the organisational parts but we should be focused on the governance of the systemic whole. It is systems that deliver care to people, organisations are fundamental and necessary but never sufficient.”
Individual/collective

There seemed to be a mystery for board members – how can so many talented and committed individuals, with so much expertise, achieve so little? All board members arrive as competent and successful individuals, and somehow the board manages to produce something that is less than the sum of its parts, except in crisis.

“I had to push really hard to get things done, because decision making in the organisation never got done. There was never any engagement of the board Sub-committees. I had to push really hard, and in the first meeting a lot of the executive directors were sitting on their hands, almost terrified. And the non executives were afraid of saying anything against me.”

NHS CHIEF EXECUTIVE ON HER INITIAL IMPRESSION OF THE BOARD.

Individually people seemed energetic, collectively they seemed miserable. We saw this during our inquiry. Energy rose when talking about an individual’s work, and dipped when talking about collective work.

From the workshops we heard that for boards to work well as a collective body they need:

(i) Relationships, better understanding of what each has to offer. Boards reported little collective understanding, ability to challenge, contest and reach new understanding, learning and curiosity.

(ii) Identity, being clear what they are for and what the work is.

(iii) Information, access to data about ‘what is’ – what’s really going on in the organisation, its environment and in the board.

“Is me the answer is dynamism, because if you have a board that is truly integrated then it is an exciting place to be. And that comes down to all the qualities of the individuals on the board, and that means to sort out the human material.”

SHAPER.

Summary of findings from part one

1. Senior managers are puzzled by the presence of different models of governance within the system
2. Governance actors are unclear about which model of governance, if any, works best
3. Governance is an inherently political activity (making judgements about public resources) – but the NHS seems to have antibodies against politics. For boards the political context further complicates already difficult work.
4. Where boards are confident in their ability to work with diverse perspectives and to take on the difficult contested decisions, then they will be working in the political domain.
5. Decisions need to be legitimate
6. Governance provides the conditions for co-produced services, and this co-production at a service level needs to be mirrored throughout the organisation.
7. Board governance needs to start from a clear view of what’s actually going on in the organisation – and patients’ real lived experience of the organisation’s / system’s service.
8. The relationship between national and local priorities is dynamic. The draw of the ‘down and in’ is crowding out the engagement of the ‘up and out’.
9. There appears to be a tension between assurance and innovation. It is not clear boards know how to govern for innovation.
10. Boards are not comfortable working strategically, where there is a requirement for challenge and engagement with the political context, and where there is tension and ambiguity. Boards look for ways of managing out ambiguity and distress.
11. Board members are not practised in giving and receiving feedback.
12. Boards need to develop their own story about their distinctive and legitimate role in delivering public value.
13. Services are delivered across many organisations; governance has to be able to ‘travel’ through the system as the patients experience it.
14. Diverse views are the source of possibility and adaptation.
15. When boards worked well all the stories were of crisis (external threat, internal concerns) – at those times there was clarity of purpose, alignment of decisions and behaviours, challenge for the sake of the task. This is not apparent in day-to-day board working.
16. The management/medicine divide prevents effective governance.
17. The NHS repeatedly reverts to linear / expert solutions, but where individuals need to work with the messiness of the whole, they struggle to know what to do.
18. It is hard to move from hierarchical behaviours to connecting and influencing behaviours.
19. The NHS has a tendency to simplify complex issues. Working with ‘wicked’ issues requires engagement, diversity and time.
20. Boards see dilemmas as ‘tame’ (simple problems with linear solutions that can be project and performance managed) and crisis (where everyone acts heroically to rescue the situation). This leads to an over-reliance on governance of the parts rather than governance of the whole.
21. Individually, board members seemed energetic, but often they didn’t seem to realise their potential as a group.
The inquiry findings part 2: How can NHS boards be more effective

The second part of the report presents research findings on the operation of boards within the NHS (England and Wales). Boards are taking on an increasingly important role but their definition, objectives and processes are not clearly spelled out or widely understood. This lack of clarity has made the analysis and reporting of the research difficult and to capture the richness of the observations made by the participants, we have grouped the research findings under the headings of:

- Board dynamics
- Research findings
- Governance literature
- Research question
- Board performance
- Governance literature
- Research question
- Board performance

To give coherence to the findings each section has the same structure of research question, research findings and implications for improving the governance model' within the NHS.

We believe the research findings offer real insights into how boards are operating, the challenges they face and possible routes for improvement. To our knowledge the research findings are new and we hope academics, directors and policy makers are all able to take something from them; and that they form a catalyst for debate and dialogue.

Board dynamics

The way boards operate - what we term board dynamics - is critical to their performance. Directors will recognise that some boards go through the motions, ticking the appropriate boxes, getting through the agenda, without fully understanding or adding value to the business. We are sure we are not alone in struggling to understand how this has happened or knowing how to change the dynamics for the good of the organisation. This section explores the causes of board dynamics and offers some suggestions as to how they can be improved.

Research findings

The first finding about board dynamics is the excessive focus on the roles of the chair and chief executive. While there are good reasons for this - the CEO is traditionally seen as running the business and the chairman as running the board - overly emphasising their importance downplays the need to develop a cohesive and effective board. The chairman and chief executive provide protection, direction and order which are useful and helpful in dealing with tame and critical problems, but unhelpful in facing the wicked problems that make up a large part of a board’s work. A commonly held perception is that the chairman and CEO take responsibility for their respective organisational units (the board and the business,) and the rest of the directors’ play supporting roles.

“I would certainly say that in my experience a precondition of good governance is an authoritative chair and an efficient chief executive. And I’ve never known an organisation sustainably managed around without the competent presence of these two roles”

A typical view is understandable if the chair and CEO are given pre-eminence and the board merely ratifies their decisions. However, this misses the opportunity to create a unit which brings out the best of the directors. Our first research finding shows that not enough attention has been given to the other directors (their roles, skills and characteristics) and the ‘chemistry’ needed to make the collective board really perform.

“A lot of executives felt really uncomfortable about the way the chair and the chief exec appeared to gloss over what was going wrong in the organisation, and they were inherently inadequate in terms of governance principle.”

We are not trying to diminish the fundamental role played by the chair within the board and the organisation as a whole. This is a principle that has been mentioned over and over in our conversations.

“I do think a good chair would certainly have a feel of what is going on, and realise if things are just getting in a circle and nothing is working as expected, which items have been adequately debated and which ones are under-discussed and hence need a bit more attention”

In response, there was an increased awareness of the board dynamics and processes. The chief executive had a clearer mandate and the board had a much more informed view of the overall direction of the trust.

Relationship between the chief executive and the board

Narrated by a Chair of the board.

“The relationship between chief exec and the board of directors had to move up a notch because of the increasing demands on the board. Being in the midst of becoming a foundation trust forced the board to work in new ways.

Previously there was a lack of open confrontation between the chief executive and board of directors because information was not being passed to the board. Consequently, board decision-making and monitoring suffered greatly. There was also widespread confusion about what the board’s role was and suspicion of a lack of commitment from both the chief executive and senior managers to the board…

We made changes to governance processes and dynamics to move the trust forward. The main priorities were to reinforce the board’s role in strategic decision making. We had to give the chief executive clear directions on how to develop the organisational strategy. Improvements in the effectiveness of the governance arrangements were achieved through the ensuring the board took full responsibility in deliberating organisational polices, the establishment of clear lines of communication, effective circulation of information amongst board members; and ensuring the chief executive took ultimate responsibility for the formulation and implementation of assessment processes. As a result, there was an increased awareness of the board dynamics and processes. The chief executive had a clearer mandate and the board had a much more informed view of the overall direction of the trust.”
A similar set of issues applies to the non-executives. They are poorly paid (compared to their private sector counterparts), and they are not given sufficient time and/or information to fully understand the organisation and the real issues that need confronting. So it is not surprising that the non-executives let the chairman and CEO drive the board and its discussions.

“What happens most of the time is that the non-executives are not allowed to challenge; they are not encouraged to fully exercise their duties, so it is problematic for them to effectively perform their functions.”

Non-executive directors represent patients and the outside community at large and therefore, given their lack of familiarity with the details and technicalities of the NHS, their main role is to offer their personal (private sector) experience (Mueller et al., 2004). Their ‘outsider’ role has clearly been legitimised through government design (Ashburner et al., 1996) with the idea of facilitating the diffusion of ‘best practices’ across sectors (Mueller et al., 2003). The executive directors, in contrast, represent a more heterogeneous category comprising career managers and professionals who have decided to “move to the other side” but still maintain strong links to the medical domain (Harrison and Pollitt, 1994).

The NHS board is made up of one set of individuals whose major interests lie elsewhere and another set who do not have the capacity to carry out the role of board director adequately. In many ways, this perpetuates the roles and positions of the chairman and CEO.

**Ineffective board dynamics**

**Narrated by a director of corporate development and member of the board.**

“The board of directors was not functioning according to the expectations of the central authorities. The board recognised this. Many of the problems throughout the organisation were not adequately tackled at board level because they were considered not a responsibility of the board as a whole but only of individuals. Tensions and disagreements between directors had grown and spread throughout the organisation. After an exhaustive analytical process, we found there was lack of cohesion and effective team environment on the board, mainly because of an ongoing feud between clinicians and managers and a split between executives and non-executives. The first thing we had to do was repair the fractures between board members, senior executives and professionals. We also decided to focus on ‘honesty’ in the whole organisation. This crisis in the functioning of the board enabled us to think deeply about what had gone wrong and allowed board members to be brought together. The introduction of more effective dynamics between board members provided the right conditions for the improvement in board performance.”

Conflict between the chairman and CEO, and between the executives and non-executives is another potential pitfall. It is too simplistic to say the chairman runs the board and the CEO runs the business. The two activities are intertwined and it is up to the two leaders to agree mutually supportive roles. Given their probable different backgrounds and experience, there will need to be real and continued efforts to keep the roles aligned. The natural tensions between the roles may well be heightened – especially if one has long standing clinical/NHS experience and the other hasn’t. This can also play a part in the tensions between executives and non-executives. There are natural tensions within NHS boards which do not have to be negative. However time and effort need to be spent understanding how these tensions can be accommodated and used for the good.

Effective team building should be a priority of every board of directors. Bevington et al. (2005) rightly point out that a team environment operating on the basis of trust and challenge creates a “mutually reinforcing circle of benefits.” Not surprisingly, Monitor expects NHS boards to provide their trust with a detailed strategic agenda and thus the effective exchange of information and data represents a necessary condition for setting strategic goals, assessing the organisational risk and monitoring service performance (Wells et al., 2006).
Implications for improving the governance model within the NHS
This brings us to how board governance can be improved. There needs to be a move from a focus on individuals to a collective team effort. This can be difficult for a board—any self appraisal is difficult but is heightened in the rarefied and highly structured environment of boards. There is no silver bullet in terms of moving from a set of individuals to an effective team and we offer a number of suggestions.

“When I was appointed I used the chief executive’s reports and did something about team working. I brought the chair to the board, to build a relationship with the other non-executives to make sure that they knew what was going on. I also worked with the two chairs of the board sub-committees in order to try to raise those questions that were concerning the functioning of the board”

If the goal is to create a team which makes the most of its diversity, promotes dialogue and debate, and is not afraid of challenge, then the first phase of development is to analyse the current ‘operations’ of the board. Here we propose the establishment of a ‘design’ team which is given the brief of analysing the board and working up a plan for improvements. If the improvements are to be lasting and meaningful, then the changes will have to be phased in: too much, too quickly and the board is likely to revert to type. A small design made up of a few board members and an external expert works best. The full board should agree the brief for the design team and expectations of what the team will need and should produce must be clearly set. This will probably require a number of meetings with the board and with directors on an individual basis, and observations of the board in action. This process will fail unless the board fully understands the benefits to be derived from it. The design process should highlight areas of structure, process, style, and interpersonal dynamics which can be improved. At the same time directors should get together outside the formal board environment to get to know, understand and appreciate each other. From these ‘social’ interactions, directors will start to appreciate each other’s strengths, weaknesses and concerns, and this will lead to more productive board meetings.

“I think that informal meetings between non-executives could be a very powerful tool, which could engender a common understanding of the agenda. If they do have concerns about the managerial side of the organisation, which they are not able to express in normal board meetings, they could talk among each other and then brief the chair. Or, why not, even bring along the chief executive as an observer/listener?”

This process of getting to know each other should stop factions forming - a common occurrence on large board. For many chairman tight, formal board meetings of individuals who barely know each other do not present a threat to their power base. It is only the chairman who is secure in his/her own authority who will welcome such changes. Another crucial area is training of board members. There are two types of training – what the individual director should know and do as a board director, and how to be part of a high performance team. Such training will need to recognise the strengths of board diversity while creating a high performing collective.

“If we have boards which are well constructed and inducted, and dare I say well chaired, then I think there are not many impossible obstacles to face.”

From their intensive work with more than 250 NHS boards, Bevington et al. (2005) conclude that effective governance is achieved not only through the application of standard practices but also through how board members interpret and behave in their different and complementary roles and functions. Boards provide strategic leadership, direction and monitoring, however they also have to ensure quality of the service, effective partnership, adequate financial management, and the involvement and care of all stakeholders, from the internal staff to the local community (Bevington et al., 2005). Crucially, Bevington et al. (2005) highlight that in high-performing boards the governance structures are aligned and fine tuned with internal processes and members’ dynamics. And the contribution of the chair is fundamental in terms of coordinating these different aspects.

Board processes
Research question
This section focuses on board processes and the following question:

Is there a lack of conflict/challenge at board level?

Underlying the question is the notion that boards often get into a rut of ratification and doing ‘business’. The board is not given the time, information and/or incentives to do any more than ‘tick the corporate boxes’. This section explores the reasons for this and what might be done to overcome it.

“That’s why boards should stick to the agenda, not with a box-ticking approach, but making sure that things are done properly. That all the members are listened to, that the right process has been followed, that the assurance framework has been inspected, and the following actions have been taken accordingly”

Research findings
One research finding that came through loud and clear is that there is a lack of understanding and appreciation between doctors and managers. In many ways there is no reason why they should understand each other’s role. Clinicians and other health professionals have developed in professional systems which focus on the practice of health and this does not normally include the notion of health as a ‘business’. Treating patients takes precedence and the business end of this is seen as taking care of itself. In addition, doctors have a long history within British society of being answerable only to themselves. Health professionals do not want to understand the business of health given the importance of treating patients. Similarly there is a lack of understanding among managers of the issues and facing doctors and other health professionals.

Undoubtedly, health care organisations are characterised by pluralistic power structures, due in part to their legacy of a complex evolution and the presence of highly qualified professionals (Abbott, 1988; Reed, 1996). The collective leadership within every organisation is the result of hierarchical relationships as well as ever changing power bases. For instance, the success of a change initiative becomes tightly interwoven with the formation of a defined leadership group representing different individual interests. Change also involves the
A lack of available data also allows boards to be driven by the chairman and CEO. A lack of data maintains the status quo and leads to the board becoming distant from the real issues. It also buttresses a lack of consultation – what the others don’t know about can’t worry about. In many ways, this is a variant of ‘information is power’ or a lack of information enables a power status quo to be maintained.

“The board members should ensure that all the crucial points (on the agenda) are covered, that all the important issues receive an adequate level of attention and are discussed appropriately. And that is why it should be crucial to have an effective board agenda and force board members to stick to it”

Quoted

“The agenda is the factor that drives the board and facilitates the work of executives and non-executives. One of the very important factors in board relationships is that boards should be effectively and constantly informed and assured that there are no other elements on the agenda. And that nothing is hidden from them”

Quoted

The lack of meaningful data drives two further research findings. First, if there is an information vacuum, directors will struggle to raise or discuss the organisational strategic requirements. Strategy in its broadest sense both derives from data and drives the data needed to move an organisation forward. It is difficult to know how a strategy could be discussed, debated or developed without access to internal and external comparisons – all of which need data. However, a lack of focus on strategy comes from other sources as well. For example, the emphasis on the chair and CEO negates a full discussion of strategy by the rest the board, as do the tensions between clinicians and management.

A second associated issue is a failure of internal channels of communication and information sharing. If the board is run from the top, there are natural tensions and data is an issue, a corollary is likely to be communication failure. This will lead to problems lower down the organisation of which the board is blissfully unaware. Similarly, decisions might be taken at board level that fail to travel down and/or be acted on by the organisation.

Ineffective exchange of information and data

Nominated by an executive director of the board.

“The structure to support the directors in the process of becoming a foundation trust was not delivering the expected results. Mistakes were made when leadership teams were put together, there was no effective exchange of information and data, scant attention to suggestions and reports from the lower level of the organisation, high turnover rate in many teams and disagreement and limited cooperation amongst team members. After a thorough examination of the problems the board made drastic changes to the way team processes were organised. Firstly, a person was put in charge of the whole process in order to improve the communication with the board. Everyone who was working on this process was required to act as a leading example to the rest of the workforce. The board also wanted to create a cooperative culture within each team. Data and information had to be administered more effectively, managed appropriately and reported to those in control of the different bits of the project.

Not only did we achieve foundation trust status but, more importantly, the trust as a whole ‘owned’ the application process and the board adopted an outward looking approach. In addition, by involving the organisation as a whole in the changes, team members became actively involved and fully engaged in the execution of different interconnected tasks. We implemented a new way of working together as a cohesive group in the organisation.”

Quoted

A final issue that has arisen through the research is a lack of consultation with wider stakeholders. boards can become isolated from the rest of the organisation and external stakeholders. Engagement with stakeholders is not an explicit part of most boards’ activities and a board has to make real efforts to make communication a key part of its activities. When this happens the impact is positive.

“The board members felt that (the consultation process) was helping them to understand a lot better what the problem was, to focus better on the real issue, to understand where we had to work, where we needed to have a bit more assurance.”

Quoted

Even when the consultation process does not work as intended, there are still positives that can be taken from it.

“It has not been a process without flaws, mistakes have been made, especially in terms of engaging the right people at the beginning. And it has tended to be a core group but many people have gone into it and many people have dropped out. And perhaps is not as representative as it should be, and lot of people in subordinate positions have not expressed their opinion on the subject... there are limitations, there are things that are never going to be changed, but at least there is a new unity, a new sense of participation”

Quoted

A further consequence of the divide is that challenge is unwelcome and alternative visions and views are not sought. A high-performing board will bring many perspectives and challenges, and deliver solutions designed and suited to the tasks at hand. If non-executive directors feel unable to question the health executives, they will struggle to perform their roles.

“I think it comes down to the point of the clarity of roles, it comes down to the fact they have a static or dynamic relationship, to the fact that on the decision day they come to the board effectively briefed and informed. So it is about information and experience”

Quoted

A second issue that arose from the research was that decision-making is constrained by a lack of internal engagement, lack of clarity of purpose, and limited inaccurate information provided to the board. Many NHS information systems have been developed over many years and they often do not ‘talk’ to each other. Much of the data needed to answer the most simple question is either not produced or arrives very late. Without the data there is little on which to base challenging discussions.

“This time we wanted people to take ownership of the process, because of the complaints we received earlier... to make them realise that this was not an easy task. We wanted to make a statement to the board in terms of you are complying with people suggestions”

Quoted
Implications for improving the governance model within the NHS:

The issues raised above suggest a number of improvements/adjustments which can be made to the governance model. First, boards must be willing to generate challenge and tolerate/exploit tensions. For many people, ambiguity is to be avoided but it is difficult to govern the NHS without an acceptance that it is part of organisational life. Challenge can be heightened and ambiguity managed if there are deep communication channels and the sharing of information across the organisation. This has to be a key objective of the governance mechanisms.

Once information and data sharing becomes a part of everyday organisational life, the board has to encourage a questioning culture. Such questioning adds to the discourse of the organisation and drives it forward through informed, critical inquiry. Such a culture needs to be present throughout the organisation, starting with the board. The board needs to commit to reviewing all board meetings and subcommittees to highlight what needs attention and what is working. Boards are no different from most human constructs in that practice and reflection is necessary for improvement. The problem is, however, that boards often struggle to find the time to commit to their basic activities never mind an improvement agenda.

Responsibility vs. accountability

Research question

Since the early 1990s increasing attention has been paid to accountability within both the private and public sectors. This has been also bound up with an increased focus on performance measurement and management. The mantra of ‘you manage what you measure’ has become dominant with league tables, key performance indicators, critical success factors and performance frameworks taking on a life of their own. This move towards accountability and measurement has a downside; namely, that the focus has shifted away from responsibility. This has allowed the individual to hide the defined measures of performance, removing a need to worry about general issues of performance. Two examples illuminate different aspects of the issue. First, consider school league tables. If a school is held accountable for its performance in school league tables, then it could, understandably, focus on maximising its league table position. In doing this it is being accountable. However, a school has a more general responsibility to educate a child to prepare him/her for life and this goes way beyond examination. So the school could be accountable but not ‘duck’ its real responsibility.

A second example emphasises the potential negative consequences of accountability/ performance measurement for general performance. Back in the early 1970s a number of UK manufacturers and engineers introduced strict performance measurement to increase productivity. This failed to appreciate that more complex engineering tasks are difficult to measure and depend on the knowledge, skill and professionalism of the worker. In essence, you don’t measure and manage performance into more complex tasks - you have to educate, train and professionalise.

The Blair government’s drive to reduce waiting lists and increase efficiency in A&E with the introduction of performance measurement standards (Kelman, 2006) have come under particular criticism for failing to consider the complex processes involved in caring for patients and therefore ultimately undermining the professionalism (see Kelman and Friedman, 2009). To improve their performance outcomes (and maintain the related level of funding) hospitals have been ‘encouraged’ to concentrate their efforts on hitting key indicators rather than taking responsibility for developing professional skills. This issue is exemplified when critical and chronic illnesses are taken into consideration, as they require a different range of skills, processes and resources than emergency medicine.

To explore this topic in more detail this section addresses the following question:

Is there a refusal to take individual responsibility? Is there too much focus on accountability?

In answering the above question we report a number of research findings.

Internal stakeholders’ consultation process

NARRATED BY THE PERSON RESPONSIBLE FOR THE PREPARATION OF REPORTS, AUDIT EXERCISES AND FEEDBACK DOCUMENTS TO THE GOVERNANCE COMMITTEE OF THE BOARD.

‘Like other PCTs we have been going through a list of changes in the past five years. Change has been top-down, with a lack of involvement from the staff. Change has been rejected or met limited support. There were two issues at work. Firstly the workforce was not consulted initially and key problems were not raised and dealt with adequately; secondly, the overall objectives and important deadlines had not been shared throughout the organisation by senior members of staff. Complaints about this have been particularly animated.

The board decided to implement a more structured and thorough consultation process. There was an initial stage of confrontation and open discussion with senior managers and departmental directors about the project. A survey questionnaire was then sent out to the workforce. After initial complaints, the consultation process was positive. Not only the board but the entire organisation as a whole had a chance to benchmark itself and gauge where it was standing. With the new consultation process employees took ownership of the entire process. I realised the difficulties and obstacles of the tasks involved and made a real contribution.

The results of the consultation process were then translated into board discussions, enabling the board to better understand the problems and to identify where resources and efforts had to be concentrated.

Another feedback survey analysed the effectiveness of the changes and whether the initial targets had been met. In brief, the consultation process subsequently became the standard procedure to communicate with the entire workforce because of its power to bring out outstanding issues and engage people’.

42 Centre for Innovation in Health Management

43 National Inquiry into Fit for Purpose Governance in the NHS: Full report
Research findings

First, there is evidence that both executive and non-executive directors lack the experience to question and move beyond simple accountability to responsibility. This is understandable when one considers the constantly changing nature of the NHS. As funding is driven, at least in part, by meeting measures of performance, then it would take a brave soul to ignore them. The issue is exacerbated by two things. First, measures and money have an immediacy which is difficult to achieve with more general notions of health. Second, there is no definite track between activity and outcome in terms of health (and there is the potential for many unintended consequences), and this will push attention to easily defined and measured outcomes.

The affirmation of accountability to the detriment of responsibility is compounded by ill defined objectives within the NHS and a lack of understanding and appreciation of the role of governance. We consider each of these points in turn. The complexity inherent in the NHS structure (and this changes fairly regularly) means it is difficult for many to fully understand the role played by their organisation and how it connects with other parts of the system. This lack of clarity is exacerbated by confusion between governance and management.

“What if (governance) can deliver and should deliver is maximum, flexible adaptability, because it will be characterised by exponential changes. A solid or steady governance is a complete waste of space and time, it is not governance at all. Governance which is not flexible cannot deliver organisations which are moving towards a different point of gravity”

“I think the crucial point is trying to understand how you flex the skeleton within the system to make it more efficient, more capable of achieving the final ends”

This may seem nebulous but it is ensuring that the organisation is given sufficient shape and direction by the actions and initiatives of key players within it. We recognise that governance is normally seen as a top-down process but we should also recognise that for governance to work it has to be owned across all levels of the organisation. If there is a lack of clarity over the goals of the organisation and what is meant by governance, then the role of the board is unclear. The eventual outcome is likely to be one of ineffectiveness on the part of the board and its directors.

“The new risk assessment process felt much more robust than the process used in the past. It really seemed that people (board members) would take ownership of the process. I think they were much more confident about it. And I felt I could really assure the board much more through this process.”

Non-executive risk manager

Lack of ownership of governance principles

Named by an assistant director of corporate development.

“We failed in our first attempt to become a foundation trust and directors felt there had been a lack of coordination and cooperation among those involved in the application process. The people in charge of the process didn’t work as a team and there was a tendency to shift individual responsibility and accountability between team members. Any form of ownership of the project was sorely lacking.

The board decided that the executive team (and not the whole board) should take the lead with the second application because of their knowledge of the nuances and peculiarities of the organisation and their ability to bring the staff on board.

The executive team looked at why the first application had failed, examined the trust’s strengths and weaknesses in terms of the requirements of the process and then implemented a new change programme based on shared responsibilities and continuous feedback loops. The team realised how a “state of crisis” (tight deadlines and specific short term targets) helped to focus the activity of the whole organisation.

Apart from the successful acquisition of foundation trust status, the board appreciated the importance of self-analysis and continuous improvement. It was a powerful learning process for everyone, showing, for example the importance of keeping the focus on both short-term and long-term targets.”

An emphasis on accountability and assurance can also be used as a defensive barrier and other matters are swept aside – if we don’t have to measure them they can’t be important. A focus on accountability can also create vested interests. For example, if cleanliness takes on increased importance, those directly related to this activity will be able to argue for increased resources at the cost of other areas. A focus on accountability and specific measures detracts from the search for ways to improve. It could be argued that without specific measures nothing will get done but we used to manage quite well without specific measures, instead the professionals got on with the job and responded to the changing needs of the organisation. Accountability and performance measurement has provided a shield to hide behind – the professionals are not responsible for the general improvement of their organisation but merely for hitting targets. Performance measurement and its corollary, accountability, run counter to what lies at the heart of professionalism – that is, the striving for improvements and meeting the highest standards.”
Development of a risk management/assurance framework

Narrated by the person brought in to facilitate and smooth the application process for foundation trust status (executive director/chief nurse).

“...in this trust the risk assurance framework was the outcome of a very isolated and bureaucratic process. No effective discussion on risk management took place between senior managers and there was an almost non-existent consultation with the rest of the organisation. The organisational culture was not oriented towards perceiving and assessing the existence of risk. While the trust operating in a safely bureaucratic process, there needed to be a more comprehensive risk management tool. The team working on the new assurance framework set specific priorities. Departmental managers and non-executive directors responsible for risk management were engaged along with other senior executives. To make the assurance framework work a new governance structure for the organisation was needed.

The governance director and the other relevant subcommittee chairs looked at the previous risk assurance framework and examined the trust in detail. An action plan was prepared and agreed upon. Two main principles were identified and supported: the direct involvement of all the staff responsible for risk management and audit and the implementation of a flexible top-down approach constantly fed with contributions and interventions from all the trust’s employees.

The new assurance framework was owned and managed throughout the organisation, with the board of directors at the forefront.”

Another pernicious aspect of accountability is that it can lead to a ‘blame culture’. With individuals and departments accountable for specific activities, there is always the tendency to lay blame at a particular door in spite of the fact that activities are inter-related and events are often the result of a myriad of forces coming together at particular moments. The whole thrust of accountability and performance measurement is one of defined causality. A further aspect of the accountability culture is that individuals become defensive in their decision making, fearful of blame and opprobrium. This leads to efforts to shift the risk of decisions onto others. The emphasis on organisational accountability leads to an ebbing away of individual responsibility. Anecdotal evidence gathered by working with NHS boards in other contexts supports this assertion, and our research has backed this up. Several board members have openly stated that they are not willing to accept direct personal responsibility unless decisions/actions are formally ratified at collective board level. “The shortcomings of the board cannot be replaced by individuals assuming responsibilities that only belong to the collegiety. Why would I put myself into trouble if the issue cannot be tackled by the whole board? I do not want to be personally exposed for matters that are clearly of board responsibility”

Compatment by a non executive director.

Compromised board and trust public reputation/image

Narrated by a non executive director.

“We decided to change the board composition and processes apply to become a foundation trust. We had an MRSA crisis and were also unable to meet some central performance targets. In terms of MRSA, senior executives had thought that the responsibility for this belonged to a team of internal experts and we did not get hold of the issue until it became public knowledge. It seemed therefore obvious that the senior people in the trust did not have a handle on important issues.

The trust was in a state of crisis and we decided to centre the rescue plan on strengthening the working of the board. We also decided to reward the workforce for meeting targets. There was a series of meetings and discussions at board level, some open to the rest of the workforce and some behind closed doors. This generated a lot of heated, emotional confrontations giving rise to important issues. A whole set of measures and performance metrics were then introduced.

Individual and group accountability has been improved and we understood the importance of cultivating challenge and debate at board level and throughout the organisation. It allowed the board to move from a mere rubber stamp to a proactive organisational tool”. This problem is exacerbated by the risk/reward balance within the NHS. There seems to be some definite costs to taking risky decisions but precious little in the way of individual rewards. The risk/reward balance adds, therefore, to risk-averse decision making, a lack of personal responsibility and acceptance of the diminished role of the individual vis-à-vis the organisation. To overcome this, there needs to be a far deeper understanding of accountability, assurance, responsibility and risk reward at both individual and organisational level.

Implications for improving the governance model within the NHS

To improve the governance model within the NHS board members have to understand the importance of taking personal and collective responsibility for the behaviours and actions of the whole board. They have to accept that they are the focus for any organisational failures and that if the organisation is progressing then mistakes will be made, as long as they are learnt from – a natural process.

“In my experience, many trusts are able to achieve transparency and accountability. And the way they achieve it is that they mediate all those inner tensions and all those competitive demands because their governance is authoritative but not authoritarian”

Organisational learning takes place when it is legitimate to contest decisions, contested decisions are actioned and eventual errors/mistakes are reviewed and discussed. These strong feedback loops are fundamental to organisational progression. This type of open and critical environment will be difficult for many directors who are used to a more passive board.

“…some committees have definitely improved, they have substantially improved their standards. So the organisation as a whole has learnt a bit about the ways it is working, and the things that were necessary to change.”

According to Currie et al. (2007), there are three major hurdles to the improvement of service quality within the NHS. Firstly, most of the knowledge that characterises the health sector is tacit in nature, tightly interwoven with practical aspects and routines and hence not easily identifiable. Secondly, the NHS is complex, with many diverse activities carried out by staff in diverse roles and functions (i.e. medical professionals vs. administrative and support staff). Thirdly, professional and operational boundaries generate mistrust and concerns that knowledge could be used detrimentally against its depositaries. There is still a long way to go before learning processes within institutionalised professional/group cultures can be successfully shared with other colleagues (Currie et al., 2007; Hudson and Henwood, 2002).
Boards and directors’ overall role

Research question

The previous sections on dynamics, processes and the tension between accountability and responsibility have highlighted the difficulties associated with being an NHS board member. A director has to grapple with a variety of structures, governance models and a whole range of different expectations.

Within this context, the question is

What is the role of the director and the board of directors, and are directors able to work on behalf of the board and organisation given all the issues/concerns raised in the previous sections?

Research findings

Trust boards provide leadership and direction which are achieved throughout the formulation and implementation of strategic plans. There is also the need for necessary control over managerial activity from the same board of directors (Bevington et al., 2005). The board can only be effective when it is open to challenge. However, constructive challenge is clearly dependent on trust, the idea that directors can safely contribute to board decision making and can count on the competence of other directors (Bevington et al., 2005). To add value to the board, it is necessary to have a clear and defined role. It is important that clarity of purpose is achieved and this clarity is almost as important as the substance of the role adopted by the board.

The implementation of the strategic plan involved a whole range of different expectations. Within this context, the question is: What is the role of the director and the board of directors, and are directors able to work on behalf of the board and organisation given all the issues/concerns raised in the previous sections?

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Implications for improving the governance model within the NHS

In improving the model of governance within the NHS, boards need to create the environment which allows them to define their roles. Here they need to broaden the lens through which they and others see the organisation. The board has to help the organisation have a clear sense of purpose and in doing this it needs to be both responsive and directive. NHS, boards have to be both responsible for service delivery and act as a cushion between central demands and the needs of the organisation. Therefore the board appointment process needs to be robust enough to ensure a range of skills and experience among its members.

Part of developing a responsive organisation is to create a board culture which gives direction and aligns the organisation with agreed objectives. This involves setting a leadership tone and integrating the board with the rest of the organisation and the external environment.

“With good governance you can make a difference, and making the difference is about governance as a leadership matter, and about transmitting good governance throughout the organisation. Leadership and governance are not just matters for the top of the organisation.”

Part of this means ensuring that the non-executive directors are fully aware of what is required of the board and themselves, and use their external networks to the benefit of the board and the wider organisation.

“Everyone has to be engaged, everyone needs to show that he or she is ready to support it. And I think it really helps to create a sense of commonality, to bring people together, to find a sense of being on the same side.”

Finally, to fulfil its role the board has to understand what is required of it and the wider organisation. It has to have the skills and experience to properly scan and map both the organisation and the environment and to be able to engage with all stakeholders.

“Directors have moved from a very inward looking perspective of trust matters to a much broader understanding of the issues faced by the organisation as a whole. They are definitely much more outward looking, which is going to help our job as a whole.”

Board performance

Research question

Does the dominance of performance management crowd out the wider role of directing and governing the organisation?

Research findings

As already highlighted a performance management culture can direct attention solely to the performance measures and make the board passive with regards to the overall direction and general performance of the organisation.

Performance measurement using governance by targets are characteristic of a centralised form of control (Beer, 1966) and, ironically, it has been applied to the health sector at the same time as other government initiatives aimed at encouraging decision making power at local level. One of the major doubts expressed about the use of governance by target is that a performance management system cannot capture the quality of the service (Pollitt, 1986). And this is a major shortcoming when dealing with general health and population wellbeing. Many managers have also criticised the fact that this system does not measure the real work performed by trusts (Green, 2005).

“We don’t think that core standards are measured in the way the service is provided. Core standards are structured to find out what the structure and systems are in place, and they do not demonstrate the outcomes of these processes and the results of the operations. I think this is a real fundamental fault in the current governance systems.”

“In my previous organisation they said they were measuring outcomes but they were not, they were measuring outputs, as they were set on targets. Therefore the focus was on activities, on what was going on. Not on whether the organisation was achieving the targets and the purposes for which is there in the first place.”

This can make board directors become passive observers rather than active designers of the governance of the organisation. It is all too easy to fall into the trap of ticking predetermined boxes and responding to the latest policy initiative from the. We have seen many examples of organisational failure within the NHS, and we believe that boards should accept responsibility in many of these situations:

“The organisation was performing quite badly, there was not reporting or enough reporting in terms of financial control, and there was no real chance to check upon executives. So the board itself was performing poorly on its targets and clinical governance processes because of the way board activity was carried out. The board committee wasn’t working at all, and there were instances were the clinical governance wasn’t taking care at all.”

Only when there is an appreciation of the tension that lies between a performance management culture and the wider brief of improving health, can boards really concentrate on the latter.

The tension is heightened by the fact that NHS boards have struggled to demonstrate strong financial management and this has driven the ‘centre’ to push for greater attention to this highly measurable and demonstrable part of management.
Ineffective performance management

Narrated by a chair of the board.

“The trust’s desire to become a foundation trust was partly driven by eagerness to demonstrate its financial viability and gain independence from the central control. It was clear to the board that the organisation’s development was dependent on us retaining our financial and non financial surpluses. The entire workforce had to see independence from central control as an important goal not only to get through the application process but also to reward everyone engaged in the project.

A basic principle, relentlessly reaffirmed by the board, was that the whole workforce had to actively participate and support the project and deliver on it. A key focus was on the financial viability of the trust, achieved by relying on the board’s financial stewardship and the reorganisation of all internal procedures and activities.

When finally recognised as a foundation trust, the board were able to enjoy operational and financial independence from the central health authorities. More crucially, the board is seen as being able to safeguard the interests of patients.

The trouble with this is that it takes the board’s focus away from understanding and assessing the needs of the various stakeholders involved in the NHS.

Improvements in financial management and health care quality

Narrated by a board director.

“Our trust had a poor reputation for financial management and the quality of care. Our plan to build a new hospital had to be a turning point in terms of achieving public recognition and demonstrating the ability to deliver a flagship project. We needed to present a successful business case and gain support from a wide range of stakeholders.

As a consequence, a complete overall of the governance of the organisation was undertaken, with a focus on driving changes and achieving efficiency.

The successful completion of the project reinforced the importance of the board as a way of overseeing the management of the trust and helping the local community. There was a considerable improvement in the quantity and quality of the facilities and improvements in patient care.

It has been known for managers to manipulate trusts’ performance measurements and related data to present individual and group outcomes in a better light (Greener and Powell, 2003). This has driven NHS organisations to expose areas where the performance was good and “hide” others where performance was poor, thus diminishing any likelihood of improvement (Greener, 2005). Not surprisingly, managers have expressed their lack of satisfaction of being relegated to a marginal role in selecting meaningful key indicators (Currie, 1999) without enough discretion and resources to cope with the imposed targets (Greener, 2005).”

Implications for improving the governance model within the NHS

As mentioned at the end of the previous section, the board needs an improved awareness of their important strategic role and the need to take a longer-term view. In doing this, the board needs to be clear of its own purpose and performance, whilst not losing sight of the values of the NHS. In driving the overall performance of the organisation, the board has to marry the emphasis on performance management with the legitimisation of a concern for the welfare of patients and their families.

In essence, the board has to be the driver of operational performance, the strategic stretch of the organisation and the custodian of the values underpinning the NHS. This is no easy task given the political imperatives from the centre and the constantly changing landscape of the NHS. If, boards take on at least some of the suggestions made in the previous sections, then there is a strong chance that the NHS and its patients will obtain the governance that we all hope for.
Key findings from part two

1. Board dynamics
   - There is an over emphasis on the chair and CEO relationship to the detriment of the productivity of the whole board.
   - Too much emphasis on the formal structure of the board and not enough on the board processes / dynamics.
   - Board members’ major interests lie outside the board, and they are not given enough information or incentives to take on the full responsibilities of board roles.
   - Tensions between the CEO and chair, and executives and non-executives are rarely productive in terms of making the most of their diversity.

Potential solutions
   - A design team should be established to enable the board to co-design the process for board working.
   - Development of board members understanding of each other and the context in which they operate.
   - Processes for making the most of the diversity of the board.

2. Board processes
   - There is a lack of understanding and appreciation between managers and clinical professionals.
   - There is too much reliance on experts.
   - Decision making is constrained by ineffective information, clarity of purpose, legitimacy and engagement.
   - Where the board is essentially the CEO - Chair, where there are unexplored tensions and challenge is not as productive; and where data is an issue, the board will be unaware of what is happening ‘on the ground’.

Potential solutions
   - Accept mistakes will happen but make sure there is learning – creating culture for contested decision making.
   - Create feedback loops to generate evidence-based decision making.

4. Boards and directors overall role
   - Directors need to give consistent messages and operate coherently to enable local organisation.
   - The board has to design specific communication processes for its work to connect with the rest of the organisation boards can operate locally to the detriment of engaging with partners and the wider context.

Potential solutions
   - Develop capability to engage with the policy and political context - mapping the environment and strategically engaging to co-create the context in which it operates.

5. Board performance
   - Centralised control leads board directors to be passive observers rather than designers of the governance system.
   - There are inherent tensions between improving health and the performance management culture.

Potential solutions
   - The board has to consistently and repeatedly pay attention to its role as custodian of NHS values; operational performance; and strategic stretch.

Conclusions and principles for good governance

In the first part of this report we stressed the idea that governance involves transferring the political process and other aspects of the authorising environment (the organisations, people that can say yes or no to the NHS Trust board’s goals) into business strategy. Boards are responsible for making first order choices by matching organisational values with system values; management is responsible for implementing these strategic choices. Accordingly, the allocation of public resources at local level is decided through boards’ discussions and actions.

We have also said that NHS boards must embrace their political function within the system, and this happens through a dialogue in which external political elements are reflected in the business plan and activity of the Trust. The principle of co-production in decision and delivery of health care requires boards to open themselves to public scrutiny as well as encouraging local communities and individual patients/users to work with them. In order to increase “public” responsibility in treatment and care choices, boards must be clear about the political and environmental context, which obviously demands a thorough and detailed scanning of the surrounding landscape. They are then responsible for aligning national and local goals by focusing on the strategic choices that shape the allocation of resources. They are then responsible for aligning national and local goals by focusing on the strategic choices that shape the allocation of resources (funding, personnel, assets, and so on). A board culture where open challenge is secured and the risk management is balanced with the ambition to innovate is paramount.

It has been said that the governance of NHS organisations forces boards to engage with the democratic process. Democratic legitimacy and accountability comprise a full commitment to delivering public value. They require boards to cultivate innovation in a safe environment and to achieve excellence in health care through active collaboration with external parties (partnership with other agencies). Again, this means that multiple perspectives must be brought into the board dialogue.

In our view, part of the problem is down to the tension between a non-expert board and the medical professionals. We do not want to criticise professionals, however we highlight the fact that in the NHS problems are traditionally solved through individual knowledge and/or expertise. This expert approach greatly compromises the possibility for those outside the profession or without accumulated expertise to contribute to the board debate. The NHS tends to divide complex issues into a series of separated and manageable activities. Consequently, there is an inclination to ignore the complexity of the whole, looking for known solutions to problems usually needing a more holistic approach. Complex problems need the skills and capabilities of everyone sitting on NHS boards contributing and co-operating as a cohesive group.

To help the reader we have summarised our ideas/suggestions in the following open list of principles of governance for NHS boards:
Principles of governance for NHS boards

1. Our Business is Health – be absolutely committed to the purpose and be able to articulate how decisions relate to purpose.
2. Ask good questions rather than feel the responsibility of providing the answers.
4. Engage with the political context – understand the role of politics.
5. Manage up and out as well as governing ‘in and down’.
6. Work out an ownership model that is explicit about rights and responsibilities and exercise accountability to owners.
7. Balance assurance and innovation.
8. Design board processes that make the most of individual energy, embrace differences and add value to the organisation.
9. Start with ‘what is’ - confront the brutal facts about the organisation know what patients are experiencing.
10. Design board processes that are fit for purpose – design conversations that do the job that’s required (which implies different discussions for strategy and assurance).
11. Ensure audible decision trails.
12. Do the difficult stuff – it takes discipline to get people out of their comfort zone.
13. Take responsibility for co-creating the context ‘stand in harm’s way rather than stand out of the way’, be active in shaping the context – get connected up and out.
14. Find a way of working with the designed-in tensions in NHS governance.
15. Take time to understand what each board member can offer, to revisit purpose and context, to review board processes – is it working for us?

In the first place, we have focused on how boards operate and the research findings have highlighted a range of interesting issues. To begin with, there seems to be an excessive focus on the role and the relationship of the chair and the chief executive within boards. They are clearly two important figures but an excessive concentration on them undermines the development of an effective and cohesive board. Similarly, too much attention is put on boards’ formal structure, ignoring the contribution of board processes and dynamics. Effective board behaviour requires a great deal of effort and overemphasis on the structure will not generate improvements.

We have seen how frequently board ineffectiveness is linked to the lack of contribution of individuals. For instance, executives may see their board responsibilities as a burden, on top of all their other duties. Moreover, non executives appear not properly involved and their skills ignored. This, in turn, leads to internal conflicts and inner tensions between board members that compromise overall board performance.

We have made a number of suggestions for improving board dynamics. It seems obvious that boards concentrate on their collective efforts, rather than relying on individuals’ contribution. This can be done in three ways:

- the introduction of a design team to understand board dynamics and devise a development plan;
- finding time and space for informal gatherings between board directors in order to increase social interaction;
- ensuring that all directors receive adequate training and direction throughout their period on the board.

Moreover, we have concentrated on the analysis of those research results related to board processes and in particular the necessary presence of active challenge at board level. Many other studies (see Greener, 2008), have noted the lack of understanding and appreciation between managers and professionals on NHS boards. Consequently, boards discourage multiple perspectives and apply models relying on historical professional knowledge. In addition decision making is compromised by a lack of internal consultation and a limited availability of relevant data and information. This forces boards to rely on an internal agenda that reflects known issues and does not facilitate the emergence of new ideas. At the same time, the strategic contribution of boards is hampered by the fact members have limited knowledge of organisational requirements. Our research has suggested that these problems are exacerbated by internal communication failure and insufficient information sharing, which do not allow internal channels to function properly. Trusts also do not successfully engage with their wider stakeholder community.

Building on our accumulated experience of the workings of NHS boards, we have come up with a series of adjustments that can be made to governance processes. We have again stressed the need for boards to be able to generate challenge and to manage the inner tensions on every board. This is the best way communication amongst directors can be fostered. This will also require a much needed cultural shift in NHS boards where not only different perspectives are put on the table but also boards are willing to face constructive criticism. Essentially, we have highlighted the need for boards to review their performance in terms of behaviours and processes.

Our research findings have also suggested that the government focus on individual and organisational accountability has driven boards away from direct responsibility and overall improvement of organisational performance. Frequently, this has been determined by a lack of specific sector experience from some board members (more likely the non executive directors) and the inability of many NHS directors and senior managers to deal with continuous structural changes.

The inherent complexity of the NHS has then been compounded by a lack of clarity on the crucial differences between governing and managing trusts. Consequently, the conversations in our workshops have pointed out how accountability and assurance are frequently used as a defence and an excuse to pursue vested interests. This has shifted the focus away from improving the delivery of health care and increased the tendency to blame other parts of the system for not reaching set targets. This is an extremely serious concern given the interconnections between many activities/functions within the NHS.

Not surprisingly, participants have suggested that board directors are increasingly fearful of public scrutiny and adopt a defensive approach, worrying about the risk of their decisions. It does not help that there exists a remarkable gap between the risks and rewards of being an NHS board director, especially in comparison with private counterparts.

As a result we suggest a shift from attention on individual responsibility to a more collective approach. Fundamentally, we believe that the whole board should be responsible for organisational failures. And errors and mistakes should not result in the guilty being identified and punished but should be a catalyst for improvements and organisational learning.

According to our participants many within the NHS are still unclear what the board and its directors’ role is. Through their directors, boards have to offer consistent leadership and direction to their organisations – something not always achieved.

We have identified two major shortcomings of ineffective NHS boards. Firstly, there is a lack of internal and external communication with the rest of the organisation and their stakeholders as if boards were operating in a sort of ivory tower. Secondly, given the pressure on the NHS in terms of performance and improvement of service quality it is not acceptable for boards to maintain a passive attitude and limit their contribution to a box-ticking approach.
The governance model we have proposed forces boards to assume a much more active role, to understand and co-create the surrounding environment. This can happen only if they accept responsibility for the delivery of health care and for acting as a political cushion between the government and the trust. For boards not working in this way, a major cultural shift will be required in terms of re-emphasising their leadership contribution and facilitating the integration with the organisation and the external environment. This would help boards to provide sound strategic direction to their trusts.

Finally, we have confirmed what other commentators have found about the dominance (tyranny) of performance management within the NHS (Hood, 2007; Bevan and Hood, 2006). Boards have a tendency to become passive when it comes to meeting performance targets. Many boards have faced serious problems in trust finances leading them to neglect the need to engage organisational stakeholders and keep monitoring the external environment.

Our belief is that boards, in line with their strategic role and a longer term vision of the organisation, have to be clear about their purpose and measure their performance according to a much wider range of indicators. This would include all the performance measures set centrally as well as, more crucially, the aim of improving the overall health of patients and their families.

In summary, the governance model we have proposed forces boards to assume a much more active role, to understand and co-create the surrounding environment. This can happen only if they accept responsibility for the delivery of health care and for acting as a political cushion between the government and the trust. For boards not working in this way, a major cultural shift will be required in terms of re-emphasising their leadership contribution and facilitating the integration with the organisation and the external environment. This would help boards to provide sound strategic direction to their trusts.

### Principles for boards practice

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

### References

Bovaird, T., 2006. Developing new relationships with the ‘market’ in the procurement of public services, Public Administration, 84, 81-102.
National Inquiry into Fit for Purpose Governance in the NHS: Full report

Quality in the new NHS

Clinical governance: dependable

Dent, M., 2006. Patient choice and medicine in change in pluralistic organizations, case study,

Deakin, N., 2002. Public-private partnerships: A UK case study,

Organisational culture and quality of health care,

Darzi, A. 2008. High Quality Care for All,

The Academy of Management Review

and data,

Daily, C. M., Dalton, D. R. and Cannella Jnr, A. A., 2000. The role of knowledge management for public services,

Public Administration

inconsistency of policy,

Currie, G. and Suhomlinova, O., 2006. The impact of institutional forces upon knowledge sharing in the UK NHS: The triumph of professional power and the inconsistency of policy,


Currie, G. and Subhrinivasu, D., 2006. The impact of institutional forces upon knowledge sharing in the UK NHS: The triumph of professional power and the inconsistency of policy,

Public Administration, 84, 1-30.


Darzi, A. 2008. High Quality Care for All,

London, TSO.


Ling, T., 2002. Delivering joined-up government in the uk: Dimensions, issues and problems, Public Administration, 80, 615-642.


Stanton, P., 2006. The role of an nhs board in assuring the quality of clinically governed care and the duty of trust to patients, Clinical Governance, 11, 39-49.


Williams, P., 2002. The competent boundary spanner, Public Administration, 80, 103.
