The Healthy NHS Board 2013

Principles for Good Governance

Foreword

We are delighted to introduce this refreshed edition of 'The Healthy NHS Board 2013 - Principles for Good Governance' commissioned by the NHS Leadership Academy.

In the period since its original publication in 2010, this guide has supported boards in their efforts to develop their governance and board effectiveness and thereby build public confidence that the NHS organisations on which patients rely provide safe, sustainable, compassionate, high quality care. However, the recent report of the Francis inquiry sets out the very significant challenges that remain for the health and social care system overall - and for the boards of NHS organisations in particular.

In this edition, the fundamental principles for good governance originally described in 'The Healthy NHS Board' remain but have been enriched by a review of the considerable body of new research and guidance that has been published over the past three years.

Wide-ranging health reform has produced a significantly changed organisational landscape and the guide also responds to these changes in organisational roles, relationships and accountabilities.

Boards are leading NHS organisations in an enormously demanding environment. The long-predicted impact of demographic change and the substantial growth in long term conditions is now upon us. Severe constraints on resources and the drive to improve efficiency, whilst protecting quality, are a daily challenge for health and social care providers alike. NHS leaders are increasingly aware that high quality, safe, sustainable healthcare depends on boards and organisations that are capable of building and maintaining mature, sophisticated partnerships across a complex, multi-faceted local health and social care economy. And although we know that the boards and staff of most NHS organisations demonstrate daily their deep commitment to providing effective, safe, compassionate care, instances of appalling failure have provided very painful lessons and have undermined public trust.

The refreshed guide shines an even brighter light than previously on the critical role that the board plays in shaping and exemplifying an organisational culture that is open, accountable and compassionate and puts patients first. Crucially, it identifies a key role for the board to play in prioritising the development of a people strategy that truly hears, supports and nurtures all staff and enables and rewards a culture of innovation and improvement. Finally it offers new insights to boards as they ensure that the organisation builds transparent, accountable relationships and partnerships with patients and the public as well as with key partners and stakeholders.

The value of robust, accountable, engaged and transparent governance has never been greater and we therefore warmly commend this resource to all boards as they seek to meet the challenges that lie ahead.

David Bennett   **David Flory**

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1 Introduction

This chapter explains the purpose of the Healthy NHS Board guidance and provides a visual summary to help readers navigate through the document.

The NHS Leadership Academy recognises the crucial importance of effective, engaged, accountable board leadership and is therefore very pleased to have commissioned this refreshed edition of 'The Healthy NHS Board 2013 - Principles for Good Governance'.

This guidance supports the NHS Leadership Academy's mission to develop outstanding leadership in health in order to improve people's health and their experience of the NHS.

The strong relationship between leadership capability and performance is well demonstrated in the evidence. Good leadership leads to a good organisational climate and good organisational climates lead, via improved staff satisfaction and loyalty, to sustainable, high performing organisations.

The updated guide has been enormously enriched by the insights of experienced, thoughtful leaders of NHS, regulatory and patient advocacy organisations who have generously responded to our call to contribute their time and their wisdom.

We are also very grateful to our partners - Monitor, the NHS Trust Development Authority, the Care Quality Commission, the Foundation Trust Network and the NHS Confederation - all of whom fielded senior leaders to join us as part of a steering group to provide advice and oversight to the process.
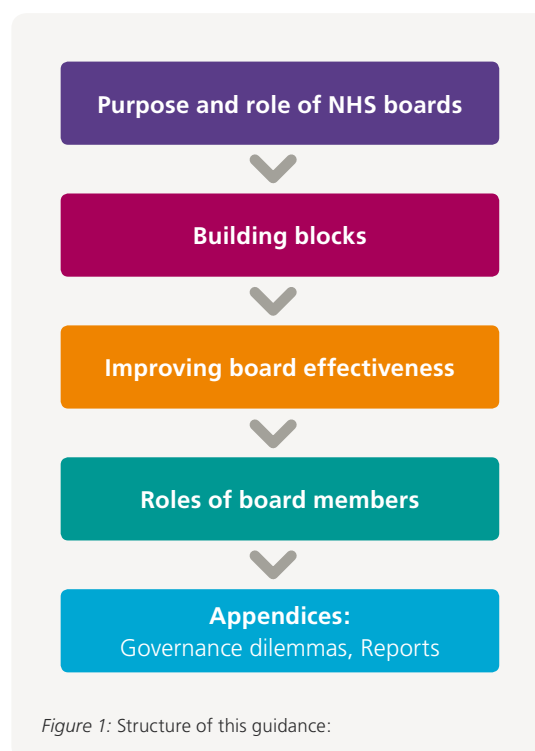
The guide will serve as a cornerstone of the Academy's wider programme of work to support and enable board and governance development. We hope that boards of NHS organisations will find that it can also serve as a cornerstone for your board development.

Karen Lynas
Deputy Managing Director, NHS Leadership Academy

Purpose of this guidance

2 This document sets out the guiding principles that will allow NHS board members to understand the:

- • Collective role of the board including effective governance in relation to the wider health and social care system

- • Activities and approaches that are most likely to improve board effectiveness in governing well.

- • Contribution expected of them as individual board members

3 It is hoped that NHS board members will continue to find this good practice guidance valuable and will focus effort in ways that the evidence suggests should be most productive. 'The Healthy NHS Board' (February 2010) was underpinned by a comprehensive review of governance literature and an extensive process of engagement with the NHS. In all, some 1,000 NHS staff and board members took part in this consultation, and the shape and content of the guide reflect their contributions. The first literature review, entitled 'The Healthy NHS Board: a review of guidance and research evidence'[42], considered over 140 sources. This second edition has again been supported by a process of engagement with leaders across the NHS. It is informed by a further review of governance research evidence and good practice guidance[42] available since the initial publication, both the original and updated reviews are available for download together at www.leadershipacademy.nhs.uk/healthyboard

4 This guidance is primarily intended for boards of NHS Trusts and Foundation Trusts. With some interpretation it will be relevant for organisations operating at a national level. Clinical Commissioning Groups, as membership organisations, have developed very specific governance architecture and are not therefore the primary focus of this guidance, although the general principles outlined are relevant to them. It offers a framework that will help them to place reliance on the effective governance of provider organisations.

5 The guidance will also be of interest to those aspiring to be NHS board members, to governors of Foundation Trusts who have a role in ensuring that the board operates effectively and to those who support and work with NHS boards.

6 This document aims to describe the enduring principles of high quality governance, that transcend immediate policy imperatives and the more pressing features of the current health care environment. It can be used by board members as an introduction to the subject of governance in the NHS. Since it is designed to be enduring, it can be kept as a reference - a first place to turn - in the future.

Purpose and role of NHS boards

⌄

Building blocks

⌄

Improving board effectiveness

⌄

Roles of board members

⌄

Appendices:
Governance dilemmas, Reports

Figure 1: Structure of this guidance:

2 Purpose and role of NHS boards

The purpose and role of NHS boards is set out in this chapter, helping board members to navigate through the wide range of guidance available.

7   The purpose of NHS boards is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands. This fundamental accountability to the public and stakeholders is delivered by building confidence:

- In the quality and safety of health services.
- That resources are invested in a way that delivers optimal health outcomes.
- In the accessibility and responsiveness of health services.
- That patients and the public can help to shape health services to meet their needs.
- That public money is spent in a way that is fair, efficient, effective and economic.

8   This guide aims to provide board members with an overarching and durable framework that will allow them to make sense, and effective use, of the wide range of available advice and guidance both in the United Kingdom and internationally. It draws on established good practice in governance and a wide-ranging review of more recent literature, from all sectors.

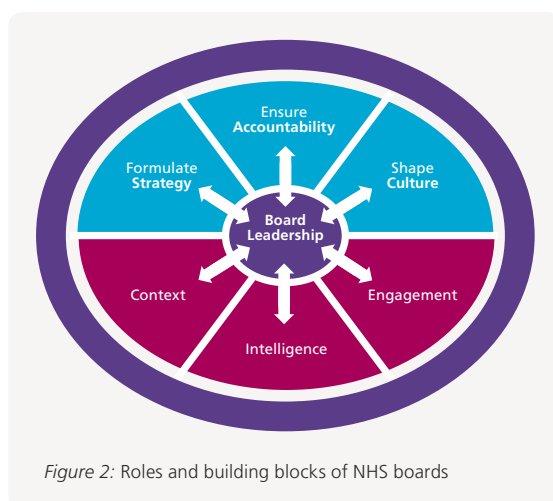9   The role of NHS boards is described below and is illustrated in Figure 2.

Figure 2: Roles and building blocks of NHS boards

10 Effective NHS boards demonstrate leadership by undertaking three key roles:

- **Formulating strategy** for the organisation.
- **Ensuring accountability by:** holding the organisation to account for the delivery of the strategy; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable.
- **Shaping a healthy culture** for the board and the organisation.

11 Underpinning these three roles are three building blocks that allow boards to exercise their role. Effective boards:

- Are informed by the **external context** within which they must operate.
- Are informed by, and shape, the **intelligence** which provides an understanding of local people's needs, trend and comparative information on how the organisation is performing together with market and stakeholder analyses.
- Give priority to **engagement** with stakeholders and opinion formers within and beyond the organisation; the emphasis here is on building a healthy dialogue with, and being accountable to, patients, the public, and staff, governors and members, commissioners and regulators.

12 The three roles of the board and the three building blocks all interconnect and influence one another. This is shown in Figure 2. They are examined in more detail in the next sections.

Roles of the board

① Formulate Strategy

13 The first of the three roles of the board is formulating strategy. There are three main elements to consider:

- The **process** of developing strategy
- The **hallmarks** of an effective strategy
- The approach to strategic **decision-making**

Strategic Process

14 In general, an effective strategic **process**:

- Ensures that the strategy, including identification of strategic options, is demonstrably shaped and owned by the board
- Provides for the active involvement of and influence by staff
- Ensures that there have been open, transparent, accountable consultation and involvement processes with patients, the community, governors and through them members (in the case of Foundation Trusts)
- Ensures that there has been collaborative engagement with partners to shape strategy in the interests of patients
- Ensures that these consultation and involvement processes help to identify strategic choices, risks and proposed ways forward
- Is underpinned by regular strategic discourse in the board, throughout the year. Strategy needs to be dynamic in responding to changes in the external environment

Hallmarks of an effective strategy

15 Some of the **hallmarks** of an effective strategy include:

Vision and purpose: putting patients first

- A compelling organisational vision for the future that puts quality of care and the safety of its patients at its heart
- A clear statement of the organisation's purpose
- Well-developed values and behaviours, owned by the organisation and supporting the desired culture to deliver the vision
- A vision that is underpinned with clear strategic objectives that are reflected in an explicit statement of desired outcomes and key performance indicators, including a balance of locally and nationally relevant indicators
- Explicit attention paid to the ability of the organisation to implement the strategy successfully
- Demonstrable influence of the needs and preferences of users, patients and communities served
- Inclusion at its heart so that services that are delivered produce accessible, fair and equitable services and outcomes for all sections of the population served
- Commitment to treating patients, service users and staff with equity
- Inspires and enables innovation
- An integrated approach to prevention and health promotion

Takes account of external context and drivers

- An approach that takes appropriate account of the external context and related risk environment in which the organisation is operating, including the organisation's responsibility as part of the wider health economy, and provides evidence of doing so

- A perspective which balances the priority given to national and local performance indicators and targets

Based on well-informed intelligence

- Evidence that the strategy has been shaped by the intelligence made available to the board (both hard and soft data)

Takes a longer term view

- A longer term view, with at least a 3 to 5 year planning horizon

- A long-term financial model and risk analysis

- A long-term people strategy (see Building Effectiveness for more information)

Strategic Decision Making

16 Strategic **decision-making** is an integral part of the board's role in formulating strategy. Good practice here includes:

- Strategic decisions which are aligned to overall strategic direction, and are expressly identified as such

- Testing strategic decisions to ensure that they balance excellence in the safety and quality of care together with long term financial sustainability and value for money

- A formal statement that specifies the types of strategic decisions, including levels of investment and those representing significant service changes that are expressly reserved for the board, and those that are delegated to committees or the executive

- Early involvement of board members in debating and shaping strategic decisions and appropriate consultation with internal and external stakeholders

- For significant strategic decisions: consideration by the board of options and analyses of those options and the board's appetite/tolerance for the major risks involved

- Criteria and rationale for decision making that are transparent, objective and evidence based

- Clarity about which key strategic decisions also require approval of governors[12] (for Foundation Trusts), such as: mergers, acquisitions, separations or dissolutions; significant increases in private patient income and amendments to the Trust's constitution

- Clarity about which strategic decisions require approval of other external organisations or bodies

'Board members should be transparent in decision-making, providing evidence, reasoning and reasons behind decisions about budget and resource allocation.'

Francis, second Inquiry report[3]

'In our organisation there are two key tests that we apply to all the decisions that we make - Would you spend your own money this way and would you wish to use this service? In this way we ensure that we have the taxpayer on one shoulder and the patient on the other.'

NHS chief executive, Healthy NHS Board consultation

Roles of the board

2 Ensure Accountability

17 The second core role of NHS boards is **ensuring accountability**. This has three main aspects:

- Holding the organisation to account for the delivery of the strategy

- Being accountable for ensuring the organisation operates effectively and with openness, transparency and candour

- Seeking assurance that the systems of control are robust and reliable

Holding the organisation to account for its performance in the delivery of strategy

18 In unitary NHS boards, all directors are collectively and corporately accountable for organisational performance.

19 This aspect is, therefore, a fundamental part of the board's role in pursuing high performance for its organisation, ensuring that the best interests of patients are central to all it does. It is important that boards are assured rather than too readily reassured. Where issues arise they need to be addressed - swiftly, decisively, knowledgeably and with humanity - by the whole unitary board. A robust but fair approach is important, particularly where there are problems of underperformance. Effective boards recognise that 'the buck stops with the board'.

Assurance: being assured because the board has reviewed reliable sources of information and is satisfied with the course of action.

Reassurance: being told by the executive or staff that performance or actions are satisfactory.

Monitor: Quality Governance Guidance [4]

20 A key observation from a review[5] of how boards get their assurance is 'that there has been no lack of guidance... the challenge for boards is therefore not finding out what to do, but instead translating the theory into an approach that works in their Trust and then following through with appropriate rigour'.

21 The fundamentals for the board in holding the organisation to account for performance include:

- Drawing on timely board <u>intelligence</u> - to monitor the performance of the organisation in an effective way and satisfy itself that performance is continually improving and that appropriate action is taken to remedy problems as they arise

- Looking beyond written intelligence to develop an understanding of the daily reality for patients and staff, to make data more meaningful

- Seeking assurance that staff are clear about their responsibilities and accountabilities and how these fit with the organisation's vision and purpose

- Triangulation[4] which ensures that board members are able to 'test' the intelligence and seek assurance by looking at more than one source and type of information, including through direct engagement with the services

- Seeking assurance of sustained improvement where remedial action has been required to address performance concerns

- Offering appreciation and encouragement where performance is excellent or improving

- Taking account of, and positively encouraging, independent scrutiny of performance, including from governors (for Foundation Trusts), regulators and overview and scrutiny committees

- Rigorous but constructive challenge from all board members, executive and non-executive as corporate board members

'Often the executive team presents a united front on an issue, which does not allow non-executives to get a feel for the divergence of opinion and views behind a recommended way ahead... but open and constructive debate among all board members, equal in status, will ensure that when a decision has been taken, it will in all probability, be the right one.'

J Deffenbaugh[6], 2012

Being accountable for ensuring the organisation operates with openness, transparency and candour

22 The board has an overarching responsibility, through its leadership and oversight, to ensure and be assured that the organisation operates with openness, transparency, and candour, particularly in relation to its dealings with patients and the public.

23 The board, itself, will be held to account by a wide range of stakeholders, for the overall effectiveness and performance of the organisation that it oversees, and the extent to which the board and the organisation operates with openness, transparency and candour. The approach to engagement of key stakeholders is described in the Engagement section.

24 One key part of this accountability includes the need for the board to ensure that published figures on all aspects of the quality of care are accurate and provide an honest and fair account to commissioners, regulators, patients and the public (see section on Intelligence for more information).

25 Boards of health and care providers will also need to be assured that the organisation is complying with the contractual duty of candour,[7] which requires providers to inform people if they believe treatment or care has caused death or serious injury.

26 Boards have a role in creating the culture which supports open dialogue. This should include directors personally listening to complaints, concerns and suggestions from patients and staff, and being seen to act on them fairly.

27 To complement this, boards need to be assured that there is a clear 'Assurance and Escalation Framework'[4] which lays out how to escalate issues and risks. Are staff clear about what they can escalate and how they should raise their concerns? Is this included in induction and training for staff? A good framework will provide clarity about how staff can raise concerns about:

- The impact of cost improvement plans on the quality of care

- Exception reporting of incidents to the board

- Identification of data quality concerns

- Early warning triggers in relation to workforce, finance and clinical services

28 A key element is ensuring that there is a clear whistle blowing policy, with support and protection for bona fide whistle blowers. The right to raise concerns should be reflected in staff contracts. Boards, through their remuneration committees, must be assured that any compromise agreements do not stop staff speaking out on matters of public interest.[8]

29 These responsibilities permeate all aspects of the leadership role of the board, including the approach taken to ensuring accountability and to shaping culture (see Culture section).

Seeking assurance that the systems of control are robust and reliable

30 This third aspect of accountability has eight elements:

- Quality governance

- Financial stewardship

- Risk management

- Legality

- Decision-making

- Probity

- Information governance

- Corporate Trustee

Quality governance

A US and equivalent English study found boards of directors of English hospitals to be far more expert and engaged in quality issues than their US counterparts, but that both US and English board chairs tend to greatly overestimate the quality performance of the hospitals they oversee.[9,10]

31 NHS organisations (providers and commissioners) have a statutory duty to secure continuous improvement of quality[11] and in practice this will be the responsibility of the board. If the board is effectively to deliver its ultimate accountability for safeguarding the quality of care received by patients it needs to give robust, systematic and consistent attention to the three key facets of quality: effectiveness and outcomes; patient safety and patient experience.

32 The board needs to become both a nurturing and driving force for continuous quality improvement across the full range of services both within the organisation and in an effective partnership with commissioners and providers along the whole patient journey.

33 It is the responsibility of the board to set and monitor fundamental standards of care. Boards are accountable to external inspectors and regulators for the quality and safety of the care provided, and are required to endorse and sign off declarations to regulators. However the board's own assurance needs to be drawn from robust internal monitoring rather than relying on reports to or from external regulators and inspectors.

34 There needs to be a clear chain of delegation that cascades accountability for delivering quality performance from the board to the point of care, ensuring that robust quality intelligence then flows back to the board.

35 Quality should be a core part of main board meetings both as a standing agenda item and as an integrated element of all major discussions and decisions. The board needs to consider quality, finance and performance decisions in the round, including a full understanding of the quality impacts of initiatives or significant service changes.

36 Boards should regularly review a quality report, including a dashboard which provides both quantitative and qualitative data at the right level of detail. The quality report should provide information in all three facets of quality. Information provided in quality reports should be clear, comparative, accurate and recent enough to be relevant. The research finding cited in the box to the left, emphasises the importance of boards being realistic about the quality performance of their organisation.

37 Boards will wish to ensure that clinical leaders are properly empowered to lead on issues relating to clinical quality. Boards benefit from regular opportunities both to take advice from clinical leaders and to reflect on ways they encourage innovative practice in relation to quality improvement. This includes encouraging managers within the organisation to respond positively to suggestions for improvement from those in clinical roles.

38 Quality performance (including monitoring of actions to maintain and improve performance) and current risks to quality of care (including controls and mitigations) should be systematically identified in the first instance by frontline clinical leaders. These are then escalated for regular, more detailed review by a quality-focused board committee with a stable, regularly attending membership that includes key clinical leaders (see section on board committees).

39 Boards should hold the organisation to account for timely, effective and compassionate complaints handling. Complaints are considered an important source of quality information. Boards also need to ensure that they understand trends and patterns in the substance of complaints.

40 Critically however, boards need to recognise that ensuring accountability in relation to quality is facilitated by more than regular board and committee scrutiny of information on quality - however exemplary. Research[42] suggests that effective quality governance demands that board members actively seek opportunities directly to hear the voice and experience of staff, patients and the public. This means that board members need regularly to step outside of the boardroom to engage directly with the reality on the ground to gain first-hand knowledge of the staff and patient experience in giving and receiving care. For Foundation Trusts, Governors can also offer boards a useful perspective and this should be actively and regularly sought. (See section on engagement).

Financial stewardship

41 The exercise of effective financial stewardship requires that the board assures itself that the organisation is operating effectively, efficiently, economically and with probity in the use of resources. It is also required to ensure that financial reporting and internal control principles are applied, and appropriate relationships with the Trust's internal and external auditors are maintained.

42 In exercising this role, it is important that financial stewardship is seen as underpinning and facilitating the delivery of quality care. This includes a careful assessment and understanding of the quality and patient care consequences of financial decisions.

43 The challenge of balancing effective financial stewardship and effective quality governance is a significant one for boards operating in a financially constrained context. Boards are encouraged to work with staff, patients and commissioners to identify opportunities for reshaping services and improving quality of care which also delivers value for money.

Risk management

44 The role of the board in risk management is twofold.

- Firstly, within the board itself an informed consideration of risk and risk tolerance should underpin organisational strategy, decision-making and the allocation of resources

- Secondly, the board is responsible for ensuring that the organisation has appropriate risk identification and risk management processes in place to deliver the annual business plan and comply with the registration and licensing requirements of key regulators. This includes systematically assessing and managing its risks. These include clinical, financial and corporate risks. For Foundation Trusts, this also includes risks to compliance with the terms of its licence

45 Oversight of effective risk management by the board is underpinned by four interlocking systems of control:

- **The Board Assurance Framework:** This is a document that sets out strategic objectives, identifies risks in relation to each strategic objective along with controls in place and assurances available on their operation. The most effective boards use this as a dynamic tool to drive the board agenda. Formats vary but the framework generally includes:

  - Objective
  - Principal risk and risk owner
  - Key controls
  - Sources of assurance
  - Gaps in control/assurance
  - Action plans for addressing gaps

- **Organisational Risk Management:** Strategic risks are reflected in the Board Assurance Framework. A more detailed operational risk register will be in use within the organisation. The board needs to be assured that an effective risk management approach is working within the organisation, and that the operational and strategic registers do join up. This involves both the design of appropriate processes and ensuring that they are properly embedded into the operations and culture of the organisation

- **Audit:** External and internal auditors play an important independent role in board assurance on internal controls, and form part of the board's second and third lines of defence, providing assurance that Executive systems of control are sufficiently comprehensive and operating effectively. There needs to be a clear line of sight from the Board Assurance Framework and the operational risk register to the programme of internal audit and a demonstrable link to the overall programme of clinical audit. Clinical audit serves as a significant source of assurance of clinical quality

- **The annual governance statement:** This is signed by the chief executive as Accountable Officer and comprehensively sets out the overall organisational approach to internal control. It should be scrutinised by the board to ensure that the assertions within it are supported by a robust body of evidence

46 The approach to risk management and related processes within the organisation need to be systematic and rigorous with risks understood and owned at the right levels. The board's risk oversight work needs to combine assurance over executive risk management processes particularly through the Audit Committee, with attention to hard and soft evidence stemming from other areas of the board's work, and identifying leading indicators that may point to escalating problems. It is crucial that boards stay alert to the reality of what is happening within the organisation. What matters substantively is recognition of, and reaction to, real risks - not unthinking pursuance of bureaucratic processes.

> **An international consultation in the wake of the financial crisis that began in 2007 suggests widespread failure of risk management was due to disconnection of the risk management system from strategy and other management systems.**

> '*The topic of risk is coming to the fore. Boards of directors are seen as a crucial mechanism through which risks are identified and managed. These include the organisation's risk appetite, risk to the strategy, risk from externalities (for example the Euro crisis), and risk caused by insufficient internal capability.*'
>
> **Chambers et al.[31]**

Legality

47 The board seeks assurance that the organisation is operating within the law and in accordance with its statutory duties. This will include seeking assurance that the organisation's contractual and commercial relationships are honest, legal and regularly monitored.

Decision making

48 The board seeks assurance that processes for operational decision making are robust and are in accordance with agreed schemes of delegation.

Probity

49 The board and its members adheres to the seven principles of public life[13] and to the Standards for NHS Board members.[14] This includes implementing a transparent and explicit approach to the declaration and handling of conflicts of interest. Good practice here includes the maintenance and publication of a register of interest for all board members. Board meeting agendas include an opportunity to declare any conflict at the beginning.

Seven Principles of Public Life	Standards for NHS Board Members
Selflessness	Responsibility
Integrity	Integrity
Objectivity	Respect
Accountability	Professionalism
Openness	Openness
Honesty	Honesty
Leadership	Leadership

50 Another key area in relation to probity relates to the effective oversight of top level remuneration. Boards are expected to adhere to HM Treasury guidance and to document and explain all decisions made.

Information Governance

51 Practising information governance means applying principles of good management and appropriate use to information. It covers all information in the organisation, including personal information (relating to patients/service users, employees and others) and corporate information (e.g. financial and accounting records).

52 Boards have a responsibility to assure themselves that the organisation has implemented adequate policies and procedures, and is addressing the responsibilities and key actions required for effective information governance. Each organisation must have a Senior Information Risk Owner (SIRO) who is effectively supported, and who updates the board regularly on information risk issues.

Corporate trustee

53 If the organisation holds NHS charitable funds as sole corporate trustee, it is jointly responsible for the management and control of those charitable funds and is accountable to the Charity Commission.

54 Some NHS organisations have a separate trustee body which manages the charitable funds linked to the work of the NHS body. Where this applies the NHS organisation does not have responsibility for charitable funds.

Committees of the board that support accountability

55 In order to enable accountability, boards are required to establish committees responsible for **audit** and **remuneration**[15]. Current good practice also recommends a quality-focused committee of the board. Over time NHS organisations have configured board committees in a variety of ways to discharge these functions. For ease of reference, these are described as three core committees which are:

1. **Audit Committee:** This committee's focus is to seek assurance that financial reporting and internal control principles are applied, and to maintain an appropriate relationship with the organisation's auditors, both internal and external. The Audit Committee offers advice to the board about the reliability and robustness of the processes of internal control. This includes the power to review any other committees' work, including in relation to quality, and to provide assurance to the board with regard to internal controls. The Audit Committee may also have responsibility for the oversight of risk management, although some Trusts have established a separate Risk Committee. The committee should be positioned as an independent source of assurance to the board and guard its independence. Ultimately however the responsibility for effective stewardship of the organisation belongs to the board as a whole.

2. **Remuneration Committee:** The duties of this committee are to determine the remuneration and terms of service for the chief executive and other executive directors, as delegated to the committee by the board; to monitor and evaluate the performance of the executive directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination payments and terms. The remuneration committee should take into account relevant nationally determined parameters on pay, pensions and compensation payments. No director should be involved in deciding his/her own remuneration. The committee may additionally have a role in succession planning for executive level roles.

3. **Quality Committee:** The ultimate accountability for quality rests with the board. However recent good practice recommends the establishment of a quality-focused board committee as a means of enhancing board oversight of quality performance and risk by ensuring input from people with particular quality expertise and responsibility for frontline clinical leadership.

This committee offers scrutiny to ensure that required standards are achieved and that action is taken where sub-standard performance is identified. It seeks assurance that the organisational systems and processes in relation to quality are robust and well-embedded so that priority is given, at the appropriate level within the organisation, to identifying and managing risks to the quality of care.

56 All board committees normally have a non-executive chair. Audit Committee members are all non-executive directors with executives in attendance as appropriate for the work being done. At least one member of the Audit Committee must have a recent and relevant financial background. Checks and balances need to be maintained in committee membership. So, for example, the board chair cannot be a member of the Audit Committee (and should not regularly attend it), nor can the Audit Committee chair be the senior independent director. Good practice suggests that the vice chair of the organisation should not chair the Audit Committee in order to avoid potential conflicts of interest.

57 Effective boards minimise the number of standing board committees. However, boards may establish other committees. Examples include finance and investment committees, risk committees[16], people strategy committees and charitable funds committees. Some FTs have also extended the remit of remuneration committees to become nomination and remuneration committees.

> '*Committees (are established) only to help the board do its job.*'
>
> **John Carver**

Roles of the board

3 Shape culture

58 The third core role of the board is shaping a healthy culture for the board and the organisation. This recognises that good governance flows from a shared ethos or culture, as well as from systems and structures. The board also takes the lead in establishing, modelling and promoting values and standards of conduct for the organisation and its staff.

59 There is now widespread recognition that the board does indeed have a key role in shaping the culture of a healthcare organisation.

60 It is important for boards to develop a good understanding of the current values, behaviours and attitudes operating within the organisation, and to work with the staff to shape the desired values, behaviours and attitudes. The challenge then is how to achieve change.

61 What we do know is that the 'how' is less about exhorting the adoption of a culture, and more about leaders of organisations being mindful of the cultural messages that they send, intentionally or passively. For example: by the board's agenda; by the nature of the debate in the board; by the relative emphasis given to different performance criteria; by how visible board members are in the organisation; by where leaders choose to invest time and resource. All of these things are culture-shaping activities.

62 We also know that how to achieve change includes an active process of dialogue and engagement with staff and service users. These ideas are developed further below.

63 The extent to which common aspects of 'culture' can be defined, identified and then deliberately changed is hotly contested within the literature on organisational culture. There is however some consensus about the value of encouraging explicit and open exploration of 'culture' at every level and in every corner of organisations. Boards have a key role in prioritising, valuing and supporting this work within the organisation.

'We would do well… to be cautious about the idea of cultural uniformity and be sceptical that top down prescriptions will bring about the desired changes. Instead the emphasis needs to be on careful nurturing, reaching for gardening metaphors in place of those rooted in ideas of engineering. Local contexts provide for organic, home-grown approaches that are sensitive to local histories and pre-occupations and real change requires detailed and sustained work on the ground.'

Davies and Manion, BMJ[17]

Shaping organisational culture

64 Effective boards shape a culture for the organisation which is caring, ambitious, self-directed, nimble, responsive, inclusive and encourages innovation. A commitment to openness, transparency and candour means that boards are more likely to give priority to the organisation's relationship and reputation with patients, the public and partners as the primary means by which it meets policy and/or regulatory requirements. As such it holds the interest of patients and communities at its heart.

- **Openness:** enabling concerns to be raised and disclosed freely without fear and for questions to be answered

- **Transparency:** allowing true information about performance and outcomes to be shared with staff, patients and the public

- **Candour:** ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it

Source: Second Francis Inquiry Report[3]

65 Boards need to recognise the importance of ensuring that the culture of their organisation reflects the NHS values, as defined in the NHS Constitution. These are:

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

66 If shaping the culture of the organisation is a vital role for boards, then embedding the culture, so that it becomes a lived reality, is equally important and arguably the most challenging part of the role.

'The cultural challenge faced by the NHS has been talked about in many ways. The key is that boards and leaders need to create environments where staff feel supported to cope with the day to day risks and challenges of health and care work. This also enables openness: mistakes will sometimes happen - staff need to know it is safe to admit them. It also enables compassion: under stress, anyone can find it hard to be caring - staff need to know it is safe to ask for support they need to really be there for patients.'

Patients First and Foremost, Department of Health[18]

'Individuals suffering from burnout may find it more difficult to feel compassion. And yet staff with higher levels of empathy are less likely to suffer from burnout. The problem that lack of compassion creates for patients is obvious, but there is also a cost for staff, who cut themselves off from feelings from which empathy and compassion could flow - especially important as, with support, higher empathy is related to lower stress.'

Schwartz Centre Rounds, Evaluation of the UK Pilot, Kings Fund[19]

67 Embedding a healthy culture across an organisation requires sustained effort and consistency of approach, often over a number of years. International research provides some helpful points on how boards can play a role in achieving desired culture change in a health context.

Culture and Innovation:

Research in the UK, in the NHS and in industry[42], has demonstrated that boards have a responsibility to embed innovation in the organisation's culture. Innovation friendly organisations have decentralised but clearly defined structures, which encourage frontline and managerial staff to innovate by allowing them freedom to make their own decision and take risks (but not at the expense of safety). Their boards avoid a top-down, rule driven approach, but do monitor, evaluate and learn. These boards actively support innovation and innovators.

Culture and Compassion:

Schwartz Centre Rounds[19] provide a forum for staff across a healthcare organisation to come together once a month to explore together the challenging psychosocial and emotional aspects of caring for patients. An independent evaluation of the Rounds showed that they have benefited both individuals and teams and have influenced hospital culture.

'Hospitals that are rated highly for patient-centred care have certain characteristics in common, one of which is 'care for the caregivers through a supportive work environment that… treats them with the same dignity and respect that they are expected to show patients and families.'

Schwartz Centre Rounds, Evaluation of the UK Pilots, King's Fund[19]

An approach to shaping culture

68 Boards should consider adopting a culture shaping process that involves active but focused dialogue and engagement with staff and service users. This approach has a great deal to offer NHS boards as they seek to shape organisational culture and, in turn, use their learning from staff and user experience to set strategy and ensure accountability.

69 As boards undertake their strategy development role, this approach could involve interactive engagement with key stakeholders, staff, members and patients, at key stages in the strategy development process. It ensures that the board as a whole is listening, learning and shaping, rather than just receiving draft strategies for approval. It is more likely to achieve a viable and responsive direction, build commitment and buy in, enrich board discussion and challenge board 'group think'.

70 Similarly, when ensuring accountability, a more interactive style of governance could move beyond paper reporting. Examples could include patient safety walk rounds, hearing patient stories at the board and staff focus groups.

71 While the importance of board visibility in the organisation has long been recognised, a more interactive process allows board members, staff and users to shape organisational values and culture through direct engagement. It also ensures that board members take back to the boardroom an enriched understanding of the lived reality for staff, users and partners.

'There has been considerable support at board level. Non-executives are committed to one or two of them attending each round. They want to understand the inhibitors to staff doing what they should.'

Schwartz Centre Rounds Evaluation[19]

Board's role in exemplifying and modelling culture

72 An outward looking board leadership culture that actively embraces change, fosters innovation, encourages learning and maintains an unswerving commitment to quality and safety of patients offers the best prospect of navigating effectively through a demanding and rapidly changing environment.

73 The board needs to be seen as champions of these values in the way the board itself operates and behaves. There are a number of facets to this. Effective boards and their members:

- Prioritise quality and patient safety

- Behave consistently in line with the seven principles of public life

- Model an open approach to learning

- Invest time to develop constructive relationships around the board table

- Reflect a drive to challenge discrimination, promote equality, diversity, equity of access and quality of services. They respect and protect human rights in the treatment of staff, patients, their families and carers, and the wider community

- Ensure that their approach to strategy, accountability and engagement are consistent with the values they seek to promote for the organisation

'The emphasis on being open to different ways of thinking encourages a learning culture, creating a system which positively seeks out new ideas and approaches with fruitful results.'

From a Canadian study of cross-sector alliances in Healthcare cited in Welbourn et al.[20]

3 Building blocks

1 Context

74 The first building block requires that boards have a comprehensive and up to date understanding of the changing external national and regional context in which they operate.

75 While many of the fundamental principles of good governance are common across a range of different types of organisations (both private and public sector), the complexity of the statutory, accountability and organisational context in which NHS boards operate is a key difference that must be fully understood by all board members. Boards operate in a demanding and changing environment. Some of these challenges are illustrated here Figure 3.

Figure 3: Challenges on NHS boards

76 The areas that boards will need to consider when developing an understanding of context are set out below:

77 **Policy:** It is important for boards to have a good understanding of the current and emerging policy direction, and the strategies for the NHS and its key partners.

78 **Economy:** Boards need to be aware of information on the economic environment for public services, and the wider economy. This assists boards in understanding the implications for future funding as well as the potential impact of economic changes on the health of the public, and the demand for health services.

79 **Legislation:** NHS bodies are subject to a wide range of legislation, from central government and from the European Union. This includes statutes, regulations and a variety of directives and Secretary of State directions.

80 **Institutional landscape:** An understanding of the structures and institutions of the NHS and those with whom the NHS does business is essential for boards to undertake their role effectively. This includes central and local government and other public and voluntary services which contribute to health and well-being.

81 **Regulation:** NHS bodies are subject to oversight from several regulators. Developing a good understanding of the most significant regulators and their requirements and expectations of NHS bodies will greatly assist boards as they steer the organisation.

82 **Public expectations:** Expectations of all public services are rising; arguably this is most pronounced in relation to the NHS. Even the most stretching national targets and standards have struggled to keep pace with mounting public expectations. The most effective NHS boards energetically develop their own understanding of trends in public and patient expectation and ensure that this actively informs their strategic choices.

83 **An understanding of the wider determinants of health status:** It is important for boards to develop an understanding of the wide range of factors that impact on health status. These include poor housing, neighbourhood deprivation, limited employment and educational opportunities, as well as the effects of affluence. This understanding helps inform the board's strategic response and shapes its whole system and partnership working.

2 Intelligence

84 Intelligence is the second key building block. It includes performance information, which can be both quantitative (such as performance metrics) and qualitative (such as staff, patient and stakeholder perspectives). It also includes information on the external local environment.

85 Boards need to be provided with information that is timely, reliable, comprehensive and suitable for board use. The Intelligent Board series[21,22,23,24,25,26] continues to offer excellent guidance to boards, and some of the key elements of this advice are summarised below. However, guidance can never be a substitute for discussion in the board aimed at evaluating the usefulness of current intelligence and shaping future intelligence requirements.

86 Intelligence that boards need to consider falls under two headings:

- Performance information including information about quality, finance and staffing

- Intelligence on the external local environment

Performance information

87 This describes how the organisation is performing both strategically and operationally. The key requirement here is that the intelligence:

- Allows the board to arrive at sound judgments about organisational performance in the delivery of strategy

- Allows the board to scrutinise operational performance 'in the round' - bringing together its appraisal of organisational performance in relation to operational activity, quality, finance and the workforce

'Multiple sources of data, and a capacity and willingness to explore contradictions in these, are prerequisites for openness to learning.'

Mannion et al., Open University Press[17,27]

88 Intelligence about **strategic performance** needs to:

- Be structured around an explicit set of strategic goals

- Show trends in performance in terms of quality, including treatment outcomes and the experience and satisfaction of patients; business development; and finance

- Provide forecasts and anticipate future performance issues

- Encourage an external focus

- Enable comparison with the performance of similar organisations, including internationally, for example through benchmarking

89 Intelligence about **operational performance** needs to:

- Provide an accurate, timely and balanced picture of current and recent performance - including patient, clinical, regulatory, staffing and financial perspectives

- Focus on the most important measures of performance, and highlight exceptions

- Be appropriately standardised in order to take account of known factors that affect outcomes, such as the age and deprivation profile of patients and communities served

- Integrate informal sources of intelligence from staff and patients

- Include consideration of assessments from key regulators including comparator information

- Enable comparisons with the performance of similar organisations

- Include key indicators in relation to a People Strategy, including:

  - workforce capacity and capability to deliver future strategy

  - intelligence on values, behaviours and attitudes

  - key HR health indicators, including information in equality and diversity

  - performance appraisal, training and development

  - leadership and management development, including talent mapping

'There is a spiral of positivity in the best performing NHS trusts. The extent to which staff are committed to their organisations and to which they recommend their trust as a place to receive treatment and to work is strongly related to patient outcomes and patient satisfaction. Climates of trust and respect characterise these top performing trusts.'

West and Dawson, NHS Staff Management and Health Service Quality[30]

Focus on Quality

90 Quality is the organising principle of the NHS and needs to be at the front of the board's mind in everything the board does.

91 While significant progress has been made in shaping and sharpening the finance and activity information generally available to boards, progress has been slower in relation to information that will allow boards to scrutinise the 'quality' of services. Quality accounts should become at least as important as financial statements for boards and be seen as a key opportunity for the board to provide the public with an open and comprehensive account of the quality of care. As such they should include a balanced account both of achievements and instances where compliance with commissioned/expected standards has not been achieved and what is being done to expedite improvement.

92 Quality comprises three dimensions:

- Clinical effectiveness or patient outcomes

- Patient safety

- Quality of the patient experience

93 As with other organisational priorities, boards should receive this information in an easily digested summary. The closer the data is to 'real time' the greater its value.

Intelligence on the external local environment

94 In the previous section on context, the emphasis was on ensuring that boards have a good grasp of the national context for health and social care. Intelligence on the **local** environment is also critical and should be as important to boards as performance information. It includes:

- **Stakeholder mapping:** One of the key challenges facing NHS boards is the complex stakeholder and accountability landscape. Boards need to have a clear grasp of the entire system within which they operate. This includes an understanding of who the key local stakeholders are, their agendas, priorities and perspectives. For Foundation Trust boards, this includes developing a good understanding of governor and member perspectives

- **Market analysis:** Likewise it is important for boards to build their understanding of the local market and the place that the organisation wishes to occupy within it

In an increasingly competitive market, boards need to keep abreast of their competitors (other NHS organisations, independent providers and the voluntary sector), including an understanding of their relative strengths and weaknesses. Considering comparative benchmarks about performance, especially on quality measures, is of strategic importance.

Market analysis can also inform potential integrated care pathways.

- **Health need and demography including diversity and equality issues.** Although these aspects are generally considered to be particularly important for commissioners, this understanding is critical in informing strategic processes for providers and in ensuring that provider boards are able to forge constructive collaborative relationships in the local health and social care economy. It includes intelligence to assist boards to understand the local population, its demographic and health profile, particularly health status, healthcare needs, behaviours and aspirations; and the key equality gaps experienced by different groups within the community, both in relation to each other and compared to similar groups in other localities. This aspect of intelligence should be based on shared analysis and monitoring with local government as well as commissioners

95 Board members have a key role to play in actively shaping and designing the sort of intelligence they wish to receive.

96 The research evidence supports the view that the provision of too much or too little information can be a significant risk to a board functioning effectively, so the key is to strike a balance between providing sufficient and meaningful information in an easily digestible format without overloading board members.

97 **A final, and important, thought on intelligence:** There is an increasing recognition that paper-based (or even tablet-based) intelligence can only take the board so far. The Board needs to ensure that it operates on the basis of a sophisticated blend between soft and hard intelligence. Direct interaction between the board and key stakeholders, including staff, provides this soft intelligence and underpins the development of strategy, it gives 'texture' to ensuring accountability and shapes a culture of openness and dialogue within the organisation. This brings us to the third key building block: engagement

3 Engagement

98 The effective board gives priority to engaging with key stakeholders and opinion formers within and beyond the organisation. Engaging effectively is vital for the board and the organisation to demonstrate its openness, transparency and accountability. There are also some circumstances where involving the public is underpinned by a legal obligation.[28]

99 Engagement informs and supports the board in creatively formulating strategy, shaping culture, and in key aspects of ensuring accountability. The range of internal and external stakeholders with which boards engage includes:

- Patients and the public.

- Members and governors (for Foundation Trusts).

- Staff from all disciplines across the organisation.

- Key partners in the wider health and social care system.

100 Engagement with staff, patients, the public and stakeholders is not new, and has long been a priority of senior leaders in NHS organisations. Boards as a whole generally receive and consider the results of these processes in the form of reports and papers.

101 Research has identified the role that direct interaction between the board and staff, patients, the public and key partners plays in effective governance.

Patient and public engagement

102 A wide range of guidance is available for boards on patient and public engagement. There are three main aspects for boards to consider:

- **Empowering people:** Patients and the public want to be able to influence the priorities of the organisations that provide healthcare. They also have the right to play a full and active part in decisions regarding their own care. Boards play an important role in setting an organisational expectation that clinical staff will actively engage patients in shared decision-making

- **Putting patient experience centre stage:** Organisations need to ensure the routine, systematic collection and analysis of feedback from people who use services, including real-time patient feedback and an understanding of the perspectives of minority and hard to reach groups. Crucially, boards need to demonstrate that this feedback, alongside intelligence on effectiveness and patient safety, actively informs board priority setting, resource allocation and decision-making. Boards benefit most from an approach that blends direct engagement with patients and their carers, the views reflected by HealthWatch and consideration of reports and papers

- **Accountability to local communities:** The organisation, and therefore the board, has a statutory 'duty to involve'.[28] In addition, the organisation exercises its local accountability through overview and scrutiny arrangements led by local government

Members and governors (for Foundation Trusts)

103 Boards of Foundation Trusts need to recognise that the autonomy and freedoms granted to them in this model rest, in large part, on effective accountability to patients and the public. This is delivered by maintaining an open and accountable relationship with governors who, in turn, engage effectively with an active membership reflective of the patients and public served by the organisation and the staff who serve them.

104 If governors are to exercise this aspect of their role effectively, they require regular and meaningful engagement with the board. Governors need to be trained and supported to work effectively with directors and to engage with the members and the wider public so that they can contribute these wider perspectives and expectations in their discussions with the board. Indeed, the provision of sufficient training to Governors is now a statutory duty.

105 This demands effort and commitment from directors, who need to demonstrate that they value the governors' contribution to the Trust. The chair is integral to developing this professional, engaged and constructive mind-set, and ensuring that directors also receive development to work effectively with governors.

'We have done a lot of work in trying to improve relationships between non-executive directors and governors. This has included setting clear expectations in job descriptions and the recruitment process that NEDs are expected to work positively with the FT governance model, and are prepared to give enough time for this.'

Foundation Trust Chair, Healthy NHS Board Consultation

Staff

106 Engagement with staff, is a vital means by which the organisation's leaders shape organisational culture. It can help boards drive culture change, for example in encouraging staff to feed into the risk management system and actively engage in quality improvement. Boards should be alert to possible differences in culture between shifts, wards and departments and what that might indicate.

107 A review[29] of how best to engage staff suggests that use of established approaches, such as surveys seeking staff opinion, are an important but not sufficient approach as they can leave engagement as an 'add-on'. Ideally, boards should aim to achieve 'transformational engagement', staff are given space to reflect and discuss improvements and see themselves as integral to developing and delivering departmental and organisational strategy. Boards can project a 'human face of leadership', fostering trust and respect, through direct engagement including holding 'Question Time' style events and participating in web-chats. For Foundation Trusts, staff governors are an important conduit for staff engagement.

108 Clinicians might be engaged to lead improvement and innovation work as 'change agents'; to provide input and leadership on quality committees; and as a key source of 'wisdom' in an engaging approach to governance.

'Trusts with higher levels of staff engagement deliver services of higher quality and perform better financially, as rated by the Care Quality Commission. They have higher patient satisfaction scores and lower staff absenteeism. They have consistently lower patient mortality rates than other trusts.'

West and Dawson, NHS Staff Management and Health Service Quality[30]

Key Partners

109 NHS boards exist within a crowded organisational landscape that includes a range of public, private and community organisations all serving broadly the same citizens. To deliver their core purpose of building public and stakeholder confidence in health and healthcare, NHS boards need to see beyond the boundaries of their individual organisations. This delicate balance involves operating within a 'community of governance' while simultaneously respecting divergent interests in a vibrant market.

110 In a financially constrained environment this becomes particularly pertinent, as boards consider options for strategic partnerships, joint management arrangements, outsourcing, major service reconfigurations, and potential mergers. But whatever the economic environment, the need to develop an effective community of governance is important because:

- Patients and users travel across organisational boundaries to receive services and tend to see the NHS as one organisation

- Approaches to health improvement and prevention, as well as tackling health inequalities can only be addressed by taking a holistic health and social care economy perspective

- Health and social care organisations at the local level share responsibility for ensuring that patients and the public get the very best value for the taxpayer resources invested

- NHS organisations and other public bodies have a legal duty to co-operate on improving local health outcomes

111 The health and social care system in England relies on a complex interplay between collaboration and competition. Boards need to reach finely balanced judgments about how they engage with this complexity.

112 The public interest is best served when all the main actors in the system reach agreement about:

- Local health need

- A shared vision for health and healthcare including health outcomes

- The 'rules of the compact' - how players within the system will work together, including the development of a culture of co-operative transparency

- Mutual understanding of, and respect for, individual organisational interests and constraints

113 This shared understanding and agreement can only be reached through regular and ongoing processes of formal and informal dialogue and relationship building. Both chair and chief executive play an important role in shaping the climate for inter-organisational engagement and in keeping lines of communication open - especially at times when negotiations may have strained relationships within their organisations. A regular cycle of whole 'board to board' processes has proved valuable in many health economies. The joint production of an annual health system development plan could also be valuable.

114 Boards are therefore advised to develop a coherent strategy for engagement with key partners. These include commissioners, NHS providers, local government, universities and further education, the voluntary sector, independent sector and of course regulators.

115 Although this stakeholder engagement is most often led by the chair and chief executive, it must form part of a systematic and agreed approach that encourages other directors and a wide range of other leaders in the organisation to be empowered to engage across organisational boundaries, informed by a shared vision and clear messages.

116 A number of boards choose to hold 'board to board' meetings with key partners. Properly focused, this can be an important part of building understanding of, and relationships with, stakeholders.

117 Ultimately however, public and stakeholder perceptions can be very significantly shaped by media messaging. The Board's engagement strategy will need to include attention to effective media management, particularly in relation to the local press.

4 Improving board effectiveness

This chapter sets out the approaches to improving board effectiveness.

118 This chapter sets out five important clusters of activity that enable boards to improve their effectiveness, shown in figure 4:

Building board capacity and capability	Enabling corporate accountability and good social practice
Exercising judgment	
Prioritising a People Strategy	Embedded board disciplines and appropriate delegations

Figure 4: Building board effectiveness

1 Building board capacity and capability

119 This involves activity in the four areas shown in the table below:

Areas of board capacity and capability building
Board composition, knowledge and skills
Whole board and individual board member performance appraisal
Systematic attention to board learning and development
Appointment and remuneration of board members

Board composition, knowledge and skills

120 NHS boards should not be so large as to be unwieldy, but must be large enough to provide the balance of skills and experience that is appropriate for the organisation. The number of directors is defined in the Trust's establishment order, or in an Foundation Trust's constitution. The composition of the board should achieve a balance between continuity and renewal. Chairs and non-executive directors (NEDs) of NHS Trusts serve a maximum of 10 years in the same NHS post (or two 3 year terms for Foundation Trusts) to ensure this balance. Within this period, any second reappointment must be through open competition.

'The benefits accrued by larger boards, particularly in relation to increased monitoring are outweighed by higher agency costs, informational asymmetry, communication and decision-making problems.'

Chambers et al., Towards a Framework for Enhancing the Performance of NHS Boards[31]

121 In most NHS organisations, governance is the responsibility of a unitary board, with at least half the board, excluding the chair, made up of independent NEDs.

122 The time commitment required of non-executive directors continues to be a focus of debate. Non-executive directors should be encouraged to look at their time requirements over an annual cycle. There will be a number of situations where more time is required than on average. This includes the first year after appointment, through the Foundation Trust application process and when the organisation is considering major strategic changes. All directors must be appropriately qualified to discharge their roles effectively, including setting strategy, monitoring and managing performance and nurturing continuous quality improvement. There is a growing emphasis on the importance of ensuring that prospective directors bring both the appropriate skills and a demonstrable commitment to NHS values - and the behaviours that these imply. Over time the strategic challenges facing boards give rise to the need for specific skills, and this requirement must be kept under review in a systematic way. In order to ensure an effective balance of knowledge, skills and backgrounds boards should undertake regular skills audits of current board members. Good practice suggests that this account of board member skills and experience as well as a clear annual board statement about its own balance, completeness and appropriateness to the requirements of it, should be available on the organisation's website.

'There should be a requirement that all Directors of bodies registered with the Care Quality Commission as well as Monitor for Foundation Trusts, are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.'

Second Francis Inquiry on Mid Staffordshire[3]

123 Guidance and research suggests that organisations are best served by boards drawn from a wide diversity of backgrounds and sectors. This includes the expectation that board composition reflects the diverse communities they serve.

'Recent research identified a tendency to 'opaque and subjective' board appointment processes. To counteract this the recommendations include proactively putting diversity on the agenda in the recruitment process, focussing more on underlying competencies than prior experience, creatively expanding the talent pool and offering support through the appointment process.'

Chambers et al.[29]

Whole board and individual board member performance appraisal

124 It is important that the whole board creates opportunities to reflect on its own performance and effectiveness. This should include a formal and rigorous annual evaluation of its own performance and that of its committees. Some boards choose to supplement self-assessment periodically with views obtained from a range of internal and external stakeholders who do not sit on the board but nonetheless experience its impact. This could include leading clinicians, senior managers who are not board members and external partners and stakeholders including patient groups and partner organisations both within and outside of the NHS.

125 It is important for boards to develop a framework of knowledge, skills and competencies that fit their organisational requirements and context and that can serve as the basis for whole board and board member appraisal.

126 Alongside whole board performance evaluation, board members should undergo an annual appraisal of their individual contribution and performance. This appraisal should focus on the director's contribution as a member of the corporate board; in the case of executive directors (EDs) this is distinct from their functional leadership role. The appraisal of the chief executive ('CE') by the chair is particularly important because the effective performance management of the CE is critical to the success of the organisation and sets the benchmark for other senior NHS managers. In a unitary board setting this is particularly necessary. Responsibilities for carrying out these appraisals are:

Role	Is appraised by
Chair (non Foundation Trusts)	NHS Trust Development Agency (NTDA)
Chair (in Foundation Trusts)	Senior independent director, drawing on the views and perspectives of Governors, fellow Directors, and key partners
Chief executive	Chair
NEDs	Chair
EDs	Chief executive with input from the chair on their contribution as a member of the board

127 A growing number of NHS boards are choosing to support the development of individual board members by undertaking a '360 degree review'. This offers board members feedback on their approach, performance and contribution from a wide range of colleagues with whom they have regular contact. This can be very helpful, though experience shows that it requires time and commitment from all board members. It must also be undertaken in a manner that respects and protects confidentiality and trust within the board. The whole process - especially individual feedback needs to be handled independently and professionally. 360 degree review approaches are intended to support individual development rather than to inform re-appointment.

128 All appraisal processes should culminate in a personal development plan, the delivery of which is actively supported by the organisation.

Systematic attention to board learning and development

129 Effective boards use the performance appraisal processes outlined above as the basis for focused board development action plans. The plan should include:

- **A structured process for induction of new board members.** This is an opportunity to attend to board members' understanding of local and - especially if they are new to the NHS - national context. Mentoring by more experienced board members can also be helpful and build relationships quickly

- **Individual board member opportunities to refresh and update skills and knowledge.** Conferences and similar events are likely to be very helpful. Organisations should ensure that board members are aware of relevant development opportunities and that new policy and contextual knowledge is systematically shared with board members, including through informal briefings between board meetings

- **Opportunities for the board to learn together.** Board development should not be limited to externally provided development events and conferences. These are valuable events, especially for the transmission of knowledge and information, but carving out time for the whole board to learn together is valuable. This is particularly true when exploring the applicability of new or innovative ways of working in the board, or when developing new skills and capabilities, for example new developments in quality improvement

'High performing hospitals and those with better performance in processes often have…greater expertise and formal training in quality.'

Chambers et al.[29]

'Those Boards that have made most sense of their own strategic goals and how to deliver them, and thereby achieved some distinctiveness and locally meaningful effectiveness have done so through dialogue'

Storey et al., The intended and unintended outcomes of new governance arrangements within the NHS[32]

130 **Opportunities to learn good practice from peers.** Board are encouraged to identify opportunities to network with and learn from peers within and beyond the health and social care system.

131 **Foundation Trust boards should give particular attention to supporting the development of governors.** Careful and comprehensive induction is critical. Foundation Trusts have a responsibility to ensure that governors have the skills and capability to deliver their core statutory functions[1,33]. Governors also need to be supported to build their skills and capacity to engage with their 'constituencies' in order to deliver and be accountable for their role.

132 **Support for chairs, chief executives and directors in challenging roles needs particular attention.** It should be clear to board members during the appointment process, if the posts are deemed challenging. Experienced directors should be appointed to these roles, and additional development support clearly agreed and put in place from an early stage.

Appointment and remuneration of board members

133 Formal, rigorous and transparent procedures for both the appointment and the remuneration of directors must be in place.

134 The appointments process must ensure that all appointments are made on merit and against objective criteria. Appointments panels for executives should always include an independent external assessor. Responsibilities for these appointments are summarised in the following table.

Role	In FTs is appointed by	In other organisations is appointed by
Chair	Governors, at a general meeting, informed by the nominations committee and/or governors working group, after taking account of advice of the board of directors	NHS Trust Development Authority ('NHS TDA') on behalf of the Secretary of State ('SoS')
Chief executive	Committee of the chair and NEDs, approved by the governors	Committee of the chair and NEDs with the NHS TDA and an independent external assessor, approved by the board
NEDs	Governors, at a general meeting, informed by the nominations committee and/or governors working group, after taking account of advice of the board of directors	NHS TDA on behalf of the SoS
EDs	Committee of the chair, chief executive and NEDs	Committee of the chair, chief executive and NEDs with the NHS TDA and an independent external assessor

135 Likewise, the responsibilities for setting
remuneration are shown in the following table

Role	In FTs remuneration is decided by	In other organisations remuneration is decided by
Chair	Governors' at a general meeting, informed by the Nominations/ Remuneration Committee or a governors working group	SoS with advice from the NHS TDA
Chief executive	Remuneration committee of at least three independent non-executive directors	Remuneration Committee of at least three non-executive directors
NEDs	Governors' at a general meeting, informed by the Nominations / Remuneration Committee or a governors working group	SoS with advice from the NHS TDA
EDs	Remuneration Committee of at least three independent non-executive directors	Remuneration Committee of at least three non-executive directors

136 The Remuneration Committee remit will be
determined by its specific terms of reference,
however, in general, it has delegated responsibility
for setting not only remuneration for the chief
executive and all executive directors, but also
including pension rights and compensation
payments. This committee also recommends and
monitors the level and structure of remuneration for
senior management.

137 Remuneration Committees are expected to consult
with external professionals to market test such
remuneration levels at least every 3 years.

2 Enabling corporate accountability and good social processes

138 In unitary NHS boards, all directors are collectively and corporately accountable for organisational performance.

139 A key strength of unitary boards is the opportunity provided for the exchange of views between executives and NEDs, drawing on and pooling their experience and capabilities.

140 Boards are 'social systems'. The most effective boards invest time and energy in the development of mature relationships and ways of working.

'It's not rules and regulations, its the way people work together.'

Jeffrey Sonnenfeld[34]

141 Some techniques and practices that support and hinder the effectiveness of these social systems are summarised in the following table.

Ways of working that support good social processes	Ways of working that obstruct good social processes
Building and publishing a crystal clear understanding of the roles of the board and individual board members	Board members behaving in a way that suggests a 'master-servant' relationship between non-executive and executive
Actively working to develop and protect a climate of trust and candour	Executive Directors only contributing in their functional leadership area rather than actively participating across the breadth of the board agenda
Building cohesion by taking steps to know and understand each other's backgrounds, skills and perspectives	Demonstrating an unwillingness to consider points of view that are different from individual directors' starting positions or being disinterested in others
Encouraging all board members to raise issues of concern and offer constructive challenges	Challenge primarily coming from non-executive directors, rather than all directors feeling empowered to challenge one another in board meetings
Sharing corporate responsibility and collective decision-making	Challenging in a way that is unnecessarily antagonistic and not appropriately balanced with appreciation, encouragement and support
Ensuring that neither chair nor chief executive power and dominance act to stifle appropriate participation in board debate	Working in ways that don't demonstrate overall confidence in the executive and that feed individual anxiety and insecurity about capability

3 Embedding board disciplines and appropriate delegation

142 Competent, systematic board disciplines form the bedrock of good board functioning. These disciplines include:

- **Giving thoughtful attention to board agenda planning and management:** The chair is central in this process, as well as seeking contributions of other board members in agenda planning. The chair needs to be vigilant in ensuring that board agendas maintain a complex range of 'balances':

  - between strategy and performance management

  - between quality, activity and finance

  - between organisational priorities and the demands of regulators

  - between information sharing (presentation) by executives and whole board discussion

  - between formal meeting time and less structured 'away' time

> International research demonstrates the value of placing quality and safety as a standing item on the board agenda.
>
> Placing quality at the top of the agenda can increase the attention given to the subject across the organisation.
>
> Dedicating significant board time to quality (at least 20%) is associated with improved quality outcomes.[14]

- Chairs face the challenge of attending to the full breadth of the board's role while ensuring that board meetings do not descend into a gruelling test of board member endurance

- **Board and committee year planners and annual programmes of work:** The board and its committees should be supported by an annual plan that sets out a coherent overall programme for formal board meetings, board seminars and away-days and committee meetings. It needs to take account of the organisational and system-wide planning cycle including key 'watershed events' such as contract negotiations, budget setting, regulatory returns and so on. It is good practice for the work of every committee of the board to be shaped by an annual plan

- **Board papers:** The effectiveness of the board is predicated on the timely availability of board papers. Increasingly boards are receiving their papers electronically, for example on tablets. Whether they are sent electronically or on paper, the core disciplines for board papers include:

  - **Timeliness:** papers provided ideally a week ahead of meetings

  - **Cover sheets:** including, for each paper, the name of the author, a brief summary of the issue, the organisational forums where the paper has been considered, the strategic objective or regulatory requirement to which it relates, and an explicit indication of what is required of the board

  - **Executive summaries:** Succinct executive summaries that direct the readers' attention to the most important aspects

- **Action logs:** Boards and committees can be helped to keep track of actions agreed by maintaining and monitoring a log. The log should show all actions agreed by the board, and for each action the 'ownership', due dates, and status

- **Declaration and resolution of conflicts of interest:**[14] Probity requires that the board maintains an up-to-date register of board members' interests. Increasingly, board agendas include an opportunity for board members to declare conflicts of interest that may relate to specific agenda items so that these can be managed appropriately

- **Transparency and openness:** There is an important obligation on public services to ensure that they operate in an open and transparent manner. For NHS organisations this is partially achieved by holding formal board meetings in public and the publication of papers. The default position ought to be that business is conducted in the public board meeting. However, when a compelling case can be made for an item to be considered in private (for example a matter that involves individual confidentiality or commercial sensitivity), there is provision for attending to it in private. Some boards follow the principles in *The Freedom of Information Act*[35] in deciding which items are considered in private

143 Foundation Trust boards are now required to hold board meetings in public, with a caveat that members of the public may be excluded from a meeting for special reasons. Foundation Trusts remain a part of the public service and thus retain the obligation to ensure openness and transparency to the public. Foundation Trust governors are required to meet in public, and also have the right to receive the agenda and minutes of board meetings.

144 Public board meetings alone are not a guarantee of transparency, and boards need to ensure that there is a wide range of ways for the public to access information about the way in which public resources are deployed. These include clear, informative, jargon-free annual reports, regular updating of an easily navigable website, the availability of key information in a range of appropriate languages and in forms that are accessible to those with disabilities.

Delegating Appropriately:

145 The formal powers of an NHS organisation are vested in the board but the NHS Code of Accountability[36] allows the board to delegate some of its business to board committees and to the executive. The board approach to delegation should be consistently set out in:

- Standing Orders which specify how the organisation conducts its business

- Standing financial instructions which detail the financial responsibilities, policies and procedures adopted

- The scheme of reservation and delegation. This sets out which responsibilities and accountabilities remain at board level and which have been delegated to committees and to the executive, together with the appropriate reporting arrangements that ensure the board has oversight

146 Approaches and schemes of delegation must be subject to regular board review to ensure that the distribution of functions and accountabilities is accurately and appropriately described, and remains appropriate despite changes in the organisation.

147 The following table lists some tests that a board should take into account when considering its committee structure.

Boards may wish to apply the following tests before establishing a new committee:
Are the proposed functions of the committee really board functions or are they executive functions?
Is a standing committee really required - or can the task be undertaken by a short life working group?
Are there good reasons why the proposed functions cannot be carried out by the whole board?
Is the committee being established because of one major incident or issue - is it a proportionate response?
Does the creation of the committee reduce clarity of role or create lack of alignment between other committees of the board and the board itself?

4 Prioritising a People Strategy

> 'There is a wealth of evidence which clearly shows that the key to providing safe, effective and compassionate care to patients is supporting and valuing staff. Staff wellbeing is not just a matter of culture. It depends on tangible elements such as good management, effective job design, education, training and appropriate resources'
>
> **Patients First and Foremost, Government response to Second Francis Report[18]**

148 NHS Boards are increasingly recognising that an effective board gives priority to the development of a 'people strategy' as a key enabler in meeting organisational strategic goals. Such a strategy straddles the following domains (see figure 5 below).

Figure 5: People strategy domains

149 In each domain, the board needs to build its understanding of:

• The current baseline position

• The position to which the board and organisation aspire to meet its strategic goals

• The focused and connected network of HR approaches and developmental interventions that will support moving the organisation and its people towards its aspiration

> 'NHS organisations routinely invest in workforce, leadership and culture change interventions. Across large and complex organisations there is, however, the risk that these interventions become fragmented and are delivered in isolation. It is also the case that boards too often have only a partial and fragmented picture of the 'people' dimensions of the business. What is needed is a comprehensive strategic human resource and organisational development approach, shaped and led by the board and recognised as a critical enabler for the delivery of strategy.'
>
> **Non-executive Director, Healthy NHS Board Consultation**

Within each of the domains, there are key questions that a robust 'people strategy' should answer. These include:

Domain	Baseline	Future
Workforce model	What is the shape of our current workforce? How have we designed our organisation in terms of structure and roles, job design? How sophisticated is our understanding of workforce costs? How diverse is our workforce?	How do we need to shape our workforce, our roles and our organisation to meet our strategic goals? What does this mean in order to develop effective multi-disciplinary working? What approach is needed to develop a diverse, inclusive workforce?

Values, behaviours and attitudes	What do we know about current values, behaviours and attitudes?
	
	What sources of information are we drawing on:
	• Staff survey
	• Patient survey
	• Patient feedback
	• Complaints and compliments
	• How do we currently engage with all of our people
	   - Board
	   - Executive
		What are the values, behaviours and attitudes to which we aspire, that will safeguard dignified and compassionate care for patients and that will underpin the delivery of our strategy?
		
		What will this mean in terms of approaches to staff engagement?

HR health indicators	What does our current performance across the range of HR indicators tell us about how effectively we are managing our staff? Which are the important leading indicators? • Turnover • Sickness • Recruitment Vacancies and time to fill Staff complaints and whistle blowing Disciplinary actions	Are these the right indicators? What level of performance would give us confidence that we are supporting our staff to perform reliably in their roles?

Table continues overleaf

Domain	Baseline	Future
Training and professional development	How effectively are we equipping our people with the right skills to undertake their roles to a high standard? What professional training and development is being offered to all staff, including through other training and education bodies - and how effectively? • What are performance appraisal rates, and what do we know about the quality of appraisals? • How are we performing in the uptake of mandatory training? • How are we approaching specific initiatives e.g. customer care or quality improvement? • Costs and value for money	What would a 'fit for purpose' approach to training and professional development look like for all staff? What approach to personal development and performance appraisal is required?
Leadership and management model	How explicit is the board about the leadership culture that it seeks to promote? How do we invest in leadership and management development? What is our approach to talent management? How do we evaluate its effectiveness? How well supported is team working?	What is the leadership model and culture that we need to promote? How do we give effect to this across all five domains? How do we describe the management model that we operate and build management competency accordingly? What is the approach to supporting team working across the organisation?

150 A good people strategy will set out the range of focused and connected organisational development interventions and HR approaches that will support moving the organisation and its people from the baseline position towards its aspiration. The key is one of 'fit', i.e. that the people strategies must fit with each other and with the overall organisational strategies for maximum impact.[37]

'Performance is seen as a function of employee ability (A), motivation (M) and opportunity to participate or contribute (O). If practices fostering these variables are enhanced, better use will be made of employee potential and discretionary judgment. In an organisational system that is truly receptive to this kind of work reform, the argument is that outcomes should be superior for both parties.'

Boxall and Purcell, 2003

5 Exercising judgment

151 This document draws the principles of effective governance from the available evidence and good practice. It is however important to recognise that at the heart of good governance is healthy debate about a spectrum of dilemmas that are not amenable to uniform guidance. Resolution of these dilemmas requires a willingness to reflect and learn good judgment and acumen on the part of the board.

152 Some of the dilemmas that present themselves to boards are set out in the appendix. They are an illustrative, not an exhaustive list. The optimal board responses to these issues cannot sensibly be mandated in guidance. Rather, boards are encouraged to set aside the necessary time to debate and explore these issues as part of their developmental journey.

5 Roles of board members

The distinct roles of members of NHS boards are outlined in this section.

153 All board members share corporate responsibility for formulating strategy, ensuring accountability and shaping culture. They also share responsibility for ensuring that the board operates as effectively as possible.

154 The chair and chief executive have complementary roles in board leadership. These are set out in more detail at the end of this section, but it is helpful to identify the essence of these two roles, which are:

- The chair leads the board and ensures the effectiveness of the board
- For Foundation Trusts, the chair also chairs the council of governors
- The chief executive leads the executive and the organisation

155 However there are also distinct roles for different members of the board, and indeed there are distinct roles depending on the type of NHS organisation.

156 These distinct roles are set out in the table overleaf, showing how they are aligned to the role of the board. The following abbreviations are used:

- **CE:** chief executive
- **NED:** non-executive director
- **ED:** executive director
- **FT:** Foundation Trust

'It is sometimes said that the board needs to be on the bridge of the ship and not in the engine room. I think it is sometimes important to go into the engine room - because how else will you know how it works? The important thing is to remember that its not your job to play with the instruments!'

NHS Chair, Healthy NHS Board Consultation

1 Roles of board members

	Chair	Chief Executive	Non-executive Director	Executive Director
Formulate Strategy	Ensures board develops vision, strategies and clear objectives to deliver organisational purpose	Leads strategy development process	Brings independence, external perspectives, skills, and challenge to strategy development	Takes lead role in developing strategic proposals - drawing on professional and clinical expertise (where relevant)
Ensure accountability	Makes sure the board understands its own accountability for governing the organisation Ensures board committees that support accountability are properly constituted Holds CE to account for delivery of strategy Leads the board in being accountable to governors and leads the council in holding the board to account.	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability Account individually and collectively to Governors for the effectiveness of the board.	Leads implementation of strategy within functional areas. Manages performance within their area and deals effectively with suboptimal outcomes
Shape culture	Provides visible leadership in developing a healthy culture for the organisation, and ensures that this is reflected and modelled in their own and in the board's behaviour and decision-making Board culture: Leads and supports a constructive dynamic within the board, enabling grounded debate with contributions from all directors	Provides visible leadership in developing a healthy culture for the organisation, and ensures that this is reflected in their own and the executive's behaviour and decision-making	Actively supports and promotes a healthy culture for the organisation and reflects this in their own behaviour Provides visible leadership in developing a healthy culture so that staff believe NEDs provide a safe point of access to the board for raising concerns	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour. Nurtures good leadership at all levels, actively addressing problems impacting staff's ability to do a good job

Table continues overleaf

	Chair	Chief Executive	Non-executive Director	Executive Director
Context	Ensures all board members are well briefed on external context	Ensures all board members are well briefed on external context	Mentors less experienced NEDs where relevant	
Intelligence	Ensures requirements for accurate, timely and clear information to board / directors (and governors for FTs) are clear to executive	Ensures provision of accurate, timely and clear information to board / directors (and governors for FTs)	Satisfies themselves of the integrity of financial and quality intelligence including getting out and about, observing and talking to patients and staff	Takes principal responsibility for providing accurate, timely and clear information to the board
Engagement	Plays key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • All staff • Key partners • Regulators	Plays key leadership role in effective communication and building strong partnerships with: • Patients and public • Member and governors (FT) • All staff • Key partners • Regulators	Ensures board acts in best interests of patients and the public Senior independent director is available to members and governors if there are unresolved concerns (FTs) Shows commitment to supporting the work of the Council of Governors (FTs)	Leads on engagement with specific internal or external stakeholder groups Shows commitment to supporting the work of the Council of Governors (FTs)

2 Board members' roles in building capacity and capability

157 The preceding table described roles of board members that are related to the role of the board as a whole. Some members have, in addition, specific responsibilities to support board effectiveness.

These specific responsibilities relate in particular to building the capacity and capability of the board. They are summarised in the following table, and explained below.

Chair	Chief Executive	Non-executive Director
Ensures that the board sees itself as a team, has the right balance and diversity of skills, knowledge and perspective, both NED and ED, and the confidence to challenge on clinical as well as other intelligence and service plans	Ensures that the executive team has the right balance and diversity of skills, knowledge and perspectives	Senior independent director assists the chairman to recognise his/her own development needs via appraisal and discussion
For FTs, supports the Governors' Nomination committee to undertake its role of appointing and appraising NEDs effectively		
With NEDs, appoints and removes the CE		NEDs including the chair, appoint and remove the chief executive.
Advises the Remuneration Committee on the appropriate remuneration for EDs		For members of the Remuneration Committee: determine appropriate remuneration for EDs
Has a prime role in appointing, and where necessary removing, executive directors, and in succession planning	With the chair, has a prime role in appointing and where necessary removing executive directors, and in succession planning	As for chair, but a particular responsibility for members of the Remuneration Committee, which supports the chair
Ensures that directors (and governors) have a full induction and continually update their skills, knowledge and familiarity with the organisation	Supports the chair in, ensuring that development programmes are in place for board members (and governors for FTs)	
Arranges regular evaluation of performance of the board, and its committees and the governors (for FTs), externally run at least every 2-3 years. Conducts regular performance reviews of the NEDs, the CE and executive directors in relation to their board contribution. Acts on the results of these evaluations, including supporting personal development planning	Uses the (board) performance evaluations as the basis for determining individual and collective professional development programmes for executive directors relevant to their duties as board members	For FTs: senior independent director (SID) and NEDs meet annually without the chair present to review the chair's performance. The SID also takes soundings from governors

'Looking is not seeing. Listening is not hearing. It is possible to miss so much that is right in front of us if we lack the categories and skills to notice. The greatest of these skills is, perhaps, to put aside our expectations, and to stay open to the actual.'

Donald M Berwick

'The role of the chair with the governors is absolutely critical. In Trusts where the model works well, the chair typically puts in a significant amount of time into developing the relationship with his or her governors and ensuring that the information flow to and from governors is effective.'

Monitor, Director-Governor Interaction in NHS FTs[38]

3 Chair and chief executive roles and relationship

158 Clarity of role and an effective working relationship between chair and chief executive are crucial to the effectiveness of the board.

159 In essence the chair leads the board and non-executive directors, and the chief executive leads the executive and the organisation. In Foundation Trusts, the chair also chairs the council of governors.

160 The table below shows a number of helpful tips and cautionary pointers for chairs and chief executives to support the development of their relationship.[39]

Tips for maintaining a good relationship

Being honest and open

Communicating well

Agreeing and reviewing clearly defined working styles and roles

Establishing trust

Building a personal relationship

Developing shared values

Promoting a 'no surprises' culture

Pointers for chairs and chief executives

Chairs should NOT...	Chief Executives should NOT...
Be too operational, interfere with details of management	Be too controlling or autocratic towards the chair
Be remote from the organisation and unknown by the majority of staff	Obstruct the Chair's access to observing services being delivered in any part of the organisation at any time
Exceed part time hours	Get too involved in NED or Chair role - e.g. no consultation on board agendas, or personally shaping them
Take specific strategic decisions alone	Break the fundamental rule of 'no surprises'
Adopt bullying, macho 'hire and fire' culture	Be too entrenched in the organisation

4 Non-executive directors' time commitment

161 This guidance does not specify the time expected of non-executive directors, but does set out some principles that may help:

- Chairs, in their board leadership role, have a key responsibility to plan and manage the time commitment required of non-executive directors in line with their role on the board in relation to strategy, accountability and culture

- Some tasks that non-executive directors are asked to do can be undertaken by other, appropriately selected and trained lay people (for example chairing appeals panels)

- Experience has shown that the higher the time commitment expected of non-executive directors, the less likely boards are to attract and retain candidates with a diverse background (such as people who are younger, of black and minority ethnic origin, women)

- There is a balance to be struck between developing a good understanding of the organisation and how it is functioning in its health economy, and getting too involved in operational matters. It is important for non-executive directors to maintain the ability for objectivity and independent scrutiny

- Newly appointed non-executive directors may find that they need and want to spend more time initially as they learn about the organisation, its people and its context

- In times of significant organisational or service change, or in the preparation for a Foundation Trust application more time is likely to be required of non-executive directors for a limited period

5 Role of the company secretary

162 The role of company secretary is well established in Foundation Trusts, and is becoming increasingly prominent in other NHS organisations.

163 The company secretary:

- Is accountable to the chair

- Ensures good information flows within the board and its committees between senior management and non-executive directors

- Facilitates induction and assists with professional development[40]

- Is responsible for advising the board through the chair on all governance matters, including ensuring that the organisation complies with the relevant legislation and regulations (and in Foundation Trusts the terms of authorisation)

- Is responsible to the board for ensuring compliance with board probity and procedures and should be accessible to all directors

164 For Foundation Trusts, the company secretary has additional responsibilities to support the council of governors.

Appendix 1

Judgment and dilemmas

165 Exercising judgment has already been identified as key to building an effective board. This appendix sets out a spectrum of dilemmas that many boards are grappling with, and yet are not amenable to uniform guidance. They are provided here to encourage boards to set aside the time to debate and explore them as part of their developmental journey.

How to ensure clarity of respective roles of governors and directors?

166 The Foundation Trust model rests to a very significant degree on robust local accountability. The council of governors plays a crucial role in ensuring that the board of directors operates in a way that is effective and accountable.

167 But the need to develop clear roles, constructive relationships and ways of working between governors and directors gives rise to a range of dilemmas including:

- How to arrive at the best balance in the governor role between the internally facing role to deliver on their formal statutory duties (including ensuring that the board of directors is performing effectively) and the externally facing role in hearing and amplifying the voice of members, patients and the public?

- How governors are supported to develop sufficient understanding of the organisation and its challenges to feel they are on a firm footing to make a constructive contribution?

- How to ensure that there is clarity in the respective roles of governors and directors?

- How governors have appropriate influence over strategic direction whilst retaining the independent voice that they need to hold the board of directors to account - how can governors avoid 'marking their own homework'?

- How much information about the board's business is shared with governors - including risk registers, and if they are what confidentiality safeguards need to be put in place?

168 The experience seems to be that responding to these dilemmas lies less in seeking 'hard and fast' rules and more in the creation of well designed, thoughtful processes to:

- Give early attention to building and maintaining a clear and shared understanding between governors and directors of the core purpose and priorities of the council of governors

- Facilitation to develop an explicit 'compact' between governors and directors about how they want to work together

- Use of the shared sense of purpose, priorities and ways of working as the basis for directors and the organisation to embrace the role and contribution of governors and proactively identify opportunities for governors to make their best contribution

Paying attention to culture: beyond exhorting a person-centred culture

169 The emerging consensus about the critical importance of organisational culture in delivering compassionate, high quality care is to be welcomed; but also prompts a range of questions for boards:

- Healthcare organisations are complex and multi-faceted and rarely have a single culture. How does the board really 'know' what the culture is - especially in the light of the lively academic debate about the extent to which culture can be 'measured'?

- To what extent can the board really shape culture in a deliberate and purposeful way?

- What sorts of approaches will help the board to move beyond exhorting the culture that it aims to shape?

170 The lessons from both success and failure seem to be:

- Boards can learn a great deal about culture by hearing about the lived daily experience of staff, patients and carers. Boards need to ensure that priority is given to hearing this experience - systematically and directly

- Attending to culture starts with shining a light on it. Which specific tool or framework is used seems less important than the permission, space and priority that is given to having the conversation - whether this is in the board, the executive, within teams at the frontline or in the feedback given and received in individual appraisal

- There are examples from both inside and outside of healthcare where culture has been successfully changed over a period of time. Learning the leadership and governance lessons from these case studies may provide important pointers for boards

Building trust with local people in a financially constrained environment

171 Most boards would wish to support an approach which suggests that 'if organisations concentrate on quality - the resources will follow' but evidence of the extent to which this is the case in practice seems inconsistent.

172 Although there are some salutary examples (notably infection control), boards are often called upon to balance competing priorities where the 'high quality care can be more cost effective' mantra is more difficult to see.

173 In the financially constrained environment within which NHS boards are operating, the challenge is for organisations to work with patients, the local community, and across the health and social care divide to identify opportunities for service integration and redesign, across patient pathways to deliver better outcomes for patients in a more cost effective way in the longer term.

174 More often than not, delivering these longer term improvements will require significant service change and these can trigger anxiety, opposition and concern in the community. It is important that boards are able to work with partners, commissioners, local people and local political leaders to help to build understanding of the choices and 'trade-offs' and thereby build public trust and confidence. Difficult service decisions may never be welcome or palatable for local people but the motivation and basis for making them can be more transparent.

175 Boards may want to anticipate and explore which approaches to working with patients and local people are likely to garner their support and enable positive service change to be made. Some approaches include:

- Early and open communication with the local community on the issues and challenges facing health services - a regular process of dialogue based on the evidence

- A track record of being consistently open and transparent

- Engaging patients, the community and key staff in early stages of shaping possible solutions, and at key stages throughout the decision making process

- Potentially using socio technological approaches to decision making which combine value for money with patient involvement[41]

- Visibility of clinicians in discussions with the community about service change

Maintaining the balance between holding to account and being accountable

176 Boards and organisations devote a great deal of time and resource responding to the demands and expectations of external regulators. This brings the risk that 'accountability' comes to mean accounting for what the organisation has done rather than taking meaningful responsibility for the performance of the organisation and its adherence to standards.

177 Flowing from the findings of both Francis Reviews, there is a growing understanding that robust assurance processes begin with the intrinsic motivation of the board to set, exemplify and monitor organisational values and fundamental standards and support staff to deliver them. External regulation should be seen as a 'failsafe' rather than a primary source of assurance.

178 Few boards would now disagree with this perspective, however the capacity of the organisation to provide robust assurance is finite. The requirements of external regulators seldom seem to begin with an assessment of the information and assurance that the organisation routinely generates.

179 These competing demands are extremely difficult to reconcile. However, it is important that boards model and encourage an approach that makes it clear that adherence to external standards is not enough. Rather, staff are expected to give robust and thoughtful attention to the standards of quality, service and conduct that matter most to them, to their patients and to carers - and that this thinking is reflected in the broader suite of standards that are set and monitored in the organisation.

Achieving a balance between managing risk and encouraging innovation

180 A systematic approach to the management of risk is one way that boards build public confidence. However, it is also clear that the future sustainability of the NHS and its founding values will require creative and innovative solutions. Some of the questions boards may wish to debate include:

- How do we ensure that risk and innovation aren't seen as mutually exclusive?

- How do boards ensure that individuals and teams within the organisation take full and active responsibility for the management of risk without creating a straightjacket of anxiety that stifles creativity?

- How does your board know about and act on good practice emerging from the literature on encouraging innovation?

- How does your board engage with the Academic Health Science Networks as well as tapping into other networks as sources of innovative practice?

Zero tolerance of poor care... in a learning organisation

181 The appropriate board response to flagrantly poor care is, hopefully now, beyond debate and prevarication.

182 Arguably more challenging are questions about care that is simply sub-optimal - the services that are persistently mediocre. The dilemma for boards is to identify the point at which they need to move from working collaboratively to gain improvement on an issue to the 'zero tolerance' point - and, having made that judgment, what that means the board does in practice.

183 There is a broad consensus that an open culture that encourages transparency and learning in response to adverse events is a key pre-requisite for reliably high quality, safe, compassionate care. How do boards ensure that in pursuing a policy of 'zero avoidable harm' they do not, inadvertently, drive a climate of fear and reduce the likelihood that staff will be open about mistakes so that the learning can be surfaced and disseminated?

184 If organisations are both to respond to resource constraints and encourage innovation, there will be a need for experimentation with new models of care - how do boards maintain a commitment to 'zero harm' whilst allowing space for innovation and experimentation?

185 To what extent are staff rewarded for bringing forward and/or implementing innovative ideas which improve quality?

Appendix 2

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