NHS
Leadership Academy

The Healthy NHS Board 2013

Review of Guidance and Research Evidence

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Addendum

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Contents

1 Executive Summary

Overview

This document has been written to support development of the updated guidance, *The Healthy NHS Board 2013: Principles for Good Governance*. It updates the review of guidance and research evidence conducted in support of the original Healthy NHS Board (Ramsay et al., 2010). It presents lessons from research and guidance published since the previous review was completed in early 2010: it therefore builds on the lessons of the previous review, but does not seek to repeat them. For a fuller picture of the evidence base, it is important that this document is read in conjunction with the original review.

As with the main guidance, the scope of this review is to provide information of relevance to boards of NHS provider organisations. Clinical Commissioning Groups have a significantly different governance structure, which means that certain sections of our review will not be relevant to boards of these organisations. However, the general principles of governance presented should be relevant to boards of all NHS organisations.

This is a review of key guidance and research published since our original review, relating to board roles and priorities, and the building blocks of governance. It is not exhaustive. For example, in considering 'people strategy', we have focused on recent research and guidance relating only to the healthcare sector, as the wider human resource management literature was too rich to capture within the scope of the current review. The review has been guided by literature searches using such terms 'board governance', 'board governance + quality', and 'board governance + engagement' for the period beginning January 2010. It has also been informed by ongoing interaction with a steering group made up of experts in healthcare board governance.

Board roles and priorities

Broadly, the lessons on board roles and priorities presented in our original review are supported by the guidance and research to have emerged since 2010. However, there are some areas of change.

In 'formulating strategy', the patient is now the key priority, and stakeholder engagement is presented as central to achieving this. 'Ensuring accountability' is now described in terms of supporting engagement and ultimately stakeholder trust, with a focus on clarity and candour. 'Shaping culture' has been increasingly recognised as important. We describe how recent research contributes to our understanding of how culture might contribute to quality, innovation and performance, and how engagement and such techniques as 'Schwartz Centre Rounds' might support shaping of a healthy culture.

The board priorities identified in our original review - quality and safety, innovation, productivity, population health, and equality and diversity - have retained their importance since our original review. Evidence indicates that boards in the English NHS have made some progress in prioritising these issues, but also that there is still room for improvement. Organisational culture and staff wellbeing may have particularly important relationships with quality of care. We note that ongoing engagement with staff, patients and the public might support further progress in delivering on these priorities.

The building blocks of governance

The building blocks of governance outlined in our original review - context, intelligence, and engagement - remain important foundations of effective board governance. The principles underlying these building blocks are broadly unchanged, though guidance and research suggest a number of lessons that develop understanding of how these should be used. For example, evidence suggests that changes in external context, for example relating to the ways in which the English NHS is re-organised, represent significant challenges to boards, but those that foster a supportive and open culture may harness these changes to encourage innovation. Intelligence remains important. It should be effective and accessible, drawing together qualitative and quantitative data: to support effective flow of information, designation of a board-level Chief Information Officer is recommended. Engagement of stakeholders - patients and the public, staff and partner organisations - has increased in prominence since our original review. Approaches to and potential benefits of engagement - for example in terms of ensuring public relevance of organisational objectives and staff wellbeing - are described.

Individual board roles

The roles of NHS provider board members have, overall, changed little since our original review was written. However, the available guidance and research evidence have grown. Therefore, we focus only on where roles have altered in guidance and how research might guide our understanding of individual board member contributions. One theme that emerges strongly is how particular board members might develop their skills and activities to support greater effectiveness of the board as a whole. Another is that both Chair and CEO have roles to ensure that executive directors contribute fully to the culture of a unitary board.

We note that in the context of NHS Foundation Trusts, the role and potential contribution of governors to board governance has grown significantly. We also note that, so far, progress in making the most of their potential contribution has been limited, and outline potential benefits of boards empowering their governors through greater engagement and training.

Board committees

The purpose and function of board committees remains broadly unchanged since our original review. We describe where the functions of committees have developed; we also present evidence on the extent to which boards in the English NHS now have a Quality Committee.

Building board effectiveness

Many of the features of boards remain broadly unchanged since our original review. Research has provided some useful lessons on how these might contribute to high quality board governance.

Research indicates that board composition, in terms of clinical background and proportion of women, might positively influence board effectiveness. In terms of process, it is recommended that effective boards prioritise quality and safety and ensure monitoring does not supplant strategy, but survey and observational research indicate that boards as yet prioritise neither sufficiently. Board culture is still regarded as a pivotal issue. However, the factors influencing this are as yet not well understood, and it is possible that structure and composition may exert an influence on culture.

'People strategy' is now identified as an additional feature of board effectiveness, reflecting how boards need to support the development of future leaders and engage with staff to ensure a healthy workforce overall.

The relationship between board characteristics and leadership effectiveness is complex, and heavily influenced by context: a 'one size fits all' mind-set is unlikely to be useful. Also, what boards do - as reflected in processes and dynamics - is likely to be at least as important as their more structural features. However, more research is needed in order to gain a clear understanding of these complex relationships.

Conclusions

Although this review is not exhaustive, we found much guidance and research to enhance our appreciation of the roles and duties of boards, and our understanding of how they add value to the organisations they lead.

Evidence and guidance on board roles and the building blocks of effective governance have increased since our original review was published. Our updated review suggests that certain issues have gained prominence since 2010. For example, the prioritisation of the quality of care and the increasing extent to which stakeholder engagement is valued is notable. Also, in the context of NHS Foundation Trusts, the developing role of governors has relevance to many aspects of board governance.

In our original review, we noted that there were several domains in which we could not draw firm conclusions. For example, associations have been found between board characteristics, board activity, organisational behaviour, and aspects of quality and performance. However, the nature and direction of causality in these associations frequently remains unclear. To reach an understanding of these matters, further research is required.

2 Introduction

2.1 Purpose and structure of the document

This document has been written to support development of the updated guidance, *The Healthy NHS Board 2013: Principles for Good Governance*. It updates the review of guidance and research evidence conducted in support of the original Healthy NHS Board (Ramsay et al., 2010). In drawing lessons from these information sources, we aim to ensure that the updated guidance reflects current recommendations on good governance and to provide an insight on the evidence supporting these recommendations.

This review seeks to present lessons from research and guidance that have become available since the previous review was completed in early 2010: it therefore builds on the lessons of the previous review, but does not seek to repeat them. For a fuller picture of the evidence base, it is important that this document is read in conjunction with the original review.

As with the main guidance, the scope of this review is to provide information of relevance to boards of NHS provider organisations. Clinical Commissioning Groups have a significantly different governance structure, which means that certain sections of our review will not be relevant to boards of these organisations. However, the general principles of governance presented should be relevant to boards of all NHS organisations.

We broadly retain the structure used in our original review. First, we present recent guidance and research evidence on the three board roles of formulating strategy, ensuring accountability and shaping culture. Second, we discuss some priorities that boards must address, including quality and safety, innovation, productivity, and equality and diversity. Third, we present evidence and guidance on the 'building blocks of governance': external context, local intelligence, and engagement of patients and the public, staff, and partner organisations, with a particular focus on recent lessons related to engagement. Fourth, we summarise recent learning in relation to specific board positions (Chair, CEO, and Executive and Non-Executive Directors) and board committees (including Audit, Remuneration, Nominations and Quality Committees).

We then present evidence and guidance on building board effectiveness (previously 'features of effective boards') covering how size, composition, processes and the culture and dynamics of boards might influence their effectiveness; we also present a section on 'people strategy', where we describe how boards might make the most of the people in the workforce and the boardroom.

This is a review of key guidance and research published since our original review, relating to board roles and priorities, and the building blocks of governance. It is not exhaustive. For example, in considering 'people strategy', we have focused on recent research and guidance relating to the healthcare sector only, as the wider human resource management literature was too rich to capture within the scope of the current review. The review has been guided by literature searches using such terms as 'board governance', 'board governance + quality', and 'board governance + engagement' for the period beginning January 2010. It has also been informed by ongoing interaction with a steering group made up of experts in healthcare board governance.

2.2 Developments since our original review

Table 1 summarises the guidance and research that we used in writing this review. For example, the report on the public inquiry into Mid Staffordshire NHS Foundation Trust was published in February 2013: it makes recommendations on providing high quality, patient-centred care at every level of the English NHS (Francis, 2013). In the corporate setting, the Financial Reporting Council published an updated code of governance and guidance on board effectiveness (Financial Reporting Council, 2011, Financial Reporting Council, 2012). In terms of research, two significant reviews have been carried out on board governance, effectiveness and development (Chambers et al., 2013, Alimo-Metcalfe, 2012).

Readers may find Table 1 (overleaf) a useful reference point as they progress through this review for detail on the provenance of the information we present.

Table 1 - Summary of key guidance and research used in this review

Note: documents coded blue are classified as reviews of the literature or original research, while documents shaded red are classified as guidance and recommendations.

Author	Title	Year	Summary
Alimo-Metcalfe, B.	Engaging boards. The relationship between governance and leadership, and improving the quality and safety of patient care	**2012**	Review of literature on how board activity is associated with healthcare organisation performance, and how boards might support a culture of safety and quality
Allen, P. et al.	Investigating the governance of autonomous public hospitals in England: multi-site case study of NHS foundation trusts	**2012**	Mixed methods research, drawing on case studies of four NHS Foundation Trusts and quantitative data on NHS hospital trusts in England. Analysis focuses on how national targets influence local behaviour, and how FT governance arrangements have supported organisational autonomy and local accountability
Allen, P. et al.	Organizational form as a mechanism to involve staff, public and users in public services: a study of the governance of NHS Foundation Trusts	**2012**	Research presenting case studies of four NHS Foundation Trusts in England. Analysis focuses on how FT governance structures support local accountability, in terms of FT membership, involvement of public and staff governors, and the relationship with other local involvement mechanisms
Appleby, J. et al.	How Cold Will It Be? Prospects for NHS funding: 2011-2017. London, King's Fund	**2009**	Analysis of possible English NHS funding scenarios and their potential outcomes
Appleby, J. et al.	Improving NHS productivity: More with the same not more of the same	**2011**	Analysis of financial situation in English NHS and discussion of strategies to improve productivity
Bennington, L.	Review of the corporate and healthcare governance literature	**2010**	Literature review covering empirical and theoretical literature in corporate and healthcare domains, drawing on 137 sources
Boorman, S.	NHS Health and Wellbeing Review	**2009**	Report based on staff survey and literature review to examine staff wellbeing and organisational performance in the context of the NHS
Büschgens, T. et al.	Organizational Culture and Innovation: A Meta Analytic Review	**2013**	Non-healthcare focused meta-analysis drawing together 43 studies exploring relationship between organisational culture and innovation

Author	Title	Year	Summary
Chambers, N.	Healthcare board governance	2012	Literature review of social science research on how healthcare boards govern for quality and safety
Chambers, N. & Cornforth, C.	The role of corporate governance and boards in organisation performance	2010	Book chapter reviewing evidence on how public and private sector boards contribute to organisational performance
Chambers, N. et al.	Towards a framework for enhancing the performance of NHS boards: a synthesis of the evidence about board governance, board effectiveness and board development	2013	Review of the theoretical and empirical literature on the composition and activities of effective boards, with a focus on the NHS
Chambers, N. et al.	Spot the Difference: A study of boards of high performing organisations in the NHS	2011	Mixed methods study of the boards of the top 19 organisations in the NHS
Charles, K. et al.	A quest for patient-safe culture: contextual influences on patient safety performance	2011	Study of 8 Acute NHS organisations in England using case study methods
Chartered Institute of Personnel and Development	Strategic human resource management	2012	Guidance on strategic human resource management, providing definitions, links to business strategy, management and performance
Committee on Standards in Public Life	Standards matter - a review of best practice in promoting good behaviour in public life	2013	Guidance on standards in public life, based on a review of 'ethically healthy' organisations
Cornforth, C. et al.	What makes chairs of governing bodies effective?	2010	Research set in the voluntary sector, based on a survey of chairs, board members, other members of staff, and volunteers
Davies, H. T. O. & Mannion, R.	Will prescriptions for cultural change improve the NHS?	2013	Comment piece in response to recommendations of final report of Francis Public Inquiry, drawing on evidence related to organisational culture, including the authors' own research
Davies, L.	Women on boards: one year on	2012	Government report on progress made in raising the proportion of female board members
Deffenbaugh, J.	It's the people in the boardroom	2012	A short review of how board relationships and personality types might influence board dynamics

Author	Title	Year	Summary
Department of Health Informatics Directorate	Guidance for NHS Boards: Information Governance	**2011**	Guidance on information governance, covering priorities, systems, and roles. Also features questions boards should ask to be assured regarding information governance
Department of Health	Innovation Health and Wealth: accelerating adoption and diffusion in the NHS	**2011**	Guidance on how the NHS might support greater innovation, e.g. through metrics, diffusion systems, procurement, and culture change
Department of Health	The NHS Constitution for England	**2013**	The updated NHS consitution
Department of Health	The handbook to the NHS Constitution for England	**2013**	Further detail on the new NHS Constitution for England
Department of Health	Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry	**2013**	English Department of Health response to Francis Report, taking a system wide focus on preventing problems, detecting problems quickly, taking action promptly, ensuring robust accountability and ensuring staff are trained and motivated
Dr Foster Intelligence	The Intelligent Board 2010: Patient Experience	**2010**	Recommendations on how boards use intelligence to get a clear sense of the experiences of patients and the public
Dr Foster Intelligence	The Intelligent Board 2011: Clinical Commissioning	**2011**	Recommendations on how CCG boards use intelligence to support effective commissioning
Financial Reporting Council	Guidance on board effectiveness	**2011**	Guidance on corporate board effectiveness
Financial Reporting Council	The UK Corporate Governance Code	**2012**	The most recent version of guidance on corporate governance (formerly 'The Combined Code')
Francis, R.	Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009	**2010**	Initial report of the inquiry into the Mid Staffordshire NHS Foundation Trust scandal, led by Robert Francis QC
Francis, R.	Report of the Mid Staffordshire NHS Foundation Trust public inquiry	**2013**	Final report of the public inquiry into the Mid Staffordshire NHS Foundation Trust scandal, led by Robert Francis QC

Author	Title	Year	Summary
Fulop, N. et al.	Implementing changes to hospital services: Factors influencing the process and 'results' of reconfiguration	2012	Research presenting three case studies analysing factors influencing implementation of hospital reconfigurations, with a focus on internal and external stakeholders
Goodall, A. H.	Physician-leaders and hospital performance: Is there an association?	2011	Cross sectional study of top 100 US hospitals, examining influence of physician CEOs
Goodrich, J.	Schwartz Center Rounds: Evaluation of the UK pilots	2011	Report describing background to Schwartz Centre Rounds, and the effects their introduction was perceived to have in two English hospitals
Guest, D. E. & Woodrow, C.	Exploring the boundaries of human resource managers' responsibilities	2012	Review of the literature exploring the extent to which HR managers can implement 'ethical' HR management
Healthcare Financial Management Association	NHS Audit Committee handbook	2011	Guidance on the Audit Committee's purpose and role. Also features information on the Assurance Framework and the overall risk assurance system
Institute of Chartered Secretaries and Administrators	Mapping the gap: highlighting the disconnect between governance best practice and reality in the NHS	2011	Report based on survey and observation data, analysing the extent to which board behaviours reflect best practice (including the original Healthy NHS Board)
Jacobs, R. et al.	The relationship between organizational culture and performance in acute hospitals	2012	Analysis of the relationship between senior management team culture (assessed using the Competing Values Framework) and organisational performance in over 100 hospitals across three time periods between 2001/02 and 2007/08
Jha, A. K. & Epstein, A. M.	A Survey Of Board Chairs Of English Hospitals Shows Greater Attention To Quality Of Care Than Among Their US Counterparts	2013	Survey of 132 chairs of English NHS organisations covering board quality governance, compared with a previous survey conducted in the US
Maben, J. et al.	Exploring the relationship between patients' experiences of care and the influence of staff motivation, affect and wellbeing	2012	Mixed methods study in 4 NHS organisations (high and low performing), drawing on interviews, observations, and staff and patient surveys

Author	Title	Year	Summary
McKee, L. et al.	Understanding the dynamics of organisational culture change: creating safe places for patients and staff.	2010	Multi method study of 8 NHS organisations in England examining how organisational culture and staff wellbeing relate to patient care.
Monitor	The NHS Foundation Trust Code of Governance.	2010	Updated Code of Governance for NHS Foundation Trusts.
Monitor	Quality governance framework.	2010	Recommendations on how boards of NHS Foundation Trusts might govern for high quality care.
Monitor	The role of boards in improving patient safety.	2010	Recommendations on how boards of NHS Foundation Trusts might govern for patient safety.
Monitor	Director-governor interaction in NHS Foundation Trusts.	2012	Recommendations on how boards of NHS Foundation Trusts and the Council of Governors should interact.
Monitor	Update to 'Your statutory duties: A draft version of the reference guide for NHS foundation trust governors	2012	Describes updated statutory duties of NHS Foundation Trust governors and how these might be carried out
Monitor	Quality Governance: How does a board know that its organisation is working effectively to improve patient care?	2013	Recommendations on how boards of NHS Foundation Trusts might govern for high quality care.
Moore, P.	Countering the biggest risk of all: attempting to uncover uncertainty in risk management.	2013	Review of evidence on aspects of risk management, presenting a model of how various components might fit together.
National Quality Board	Quality governance in the NHS - a guide for provider boards.	2011	Recommendations for NHS Provider organisations on how they might govern for high quality care.
Ocloo, J. et al.	Empowerment or Rhetoric? Investigating the Role of NHS Foundation Trust Governors in the Governance of Patient Safety.	2013	Research drawing together national survey data and qualitative methods. Analysis focuses on involvement of lay governors in formal governance structures to improve patient safety.
Professional Standards Authority	Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England.	2012	A series of statements reflecting how NHS board members should act, categorised in terms of personal behaviour, technical competence and business practices.

Author	Title	Year	Summary
Storey, J. et al.	The intended and unintended outcomes of new governance arrangements within the NHS	**2010**	Mixed methods study of 14 NHS organisations, drawing on interview and survey data collected mostly in 2008
Storey, J. et al.	Governing the New NHS: Issues and tensions in health service management	**2012**	Book covering numerous aspects of governance and how they interact. There is a particular focus on board effectiveness and development
The King's Fund	Leadership and Engagement for Improvement in the NHS: Together We Can	**2012**	Main report of King's Fund programme on engaging leadership
Veronesi, G. & Keasey, K.	A (new) model of board of directors: evidence from the National Health Service	**2012**	Study analysing 22 English NHS Trusts, using qualitative case study methods, examining the effects of the Foundation Trust governance system
Veronesi, G. et al.	Clinicians in Management: Does it make a difference?	**2012**	Desk-based analysis of over 100 NHS trusts from 2006/07 - 2008/09, drawing on board membership (professional background) and trust performance (Annual Health check ratings, Hospital Standardised Mortality Ratio, National Patient Survey), controlling for other organisational characteristics
Welbourn, D. et al.	Leadership of whole systems	**2012**	Review of evidence, providing definitions of management and leadership, describing the concept of systems and outlining approaches to effective leadership across systems
West, M. et al.	NHS Staff Management and Health Service Quality	**2010**	Analysis drawing on NHS staff survey and in-patient survey data 2006-09, tied to staff engagement, and a range of outcomes, including staff wellbeing, patient satisfaction, service quality, financial performance and infection rates and errors

Author	Title	Year	Summary
Woodrow, C. & Guest, D. E.	When good HR gets bad results: exploring the challenge of HR implementation in the case of workplace bullying.	**2013**	Mixed methods study of bullying and harassment in one English NHS trust from 2008-09.
Wright, J. et al.	The new governance arrangements for NHS Foundation Trust hospitals: reframing governors as meta-regulators.	**2011**	Qualitative study of four NHS Foundation Trusts. Analysis focuses on members and governors, in terms of motivation to become involved, and the roles, functions and effectiveness of governors and members in the governance of these organisations.

3 Role of NHS boards

The English Department of Health's response to the final report of the Mid Staffordshire NHS Foundation Trust public inquiry (Francis, 2013) states that boards 'have the principal responsibility for ensuring that care in their organisations is safe and that those who use their services are treated as individuals, with dignity and compassion' (Department of Health, 2013c). Below, we present how recent research and guidance suggest boards might achieve this through their roles of formulating strategy, ensuring accountability, and shaping culture.

Broadly, the lessons on board roles and priorities presented in our original review are supported by the guidance and research to have emerged since 2010. However, there are some areas of change, which we summarise here.

In 'formulating strategy', the patient is now the key priority, and stakeholder engagement is presented as central to achieving this. 'Ensuring accountability' is now described in terms of supporting engagement and ultimately stakeholder trust. In support of this, clarity and candour are important: boards should prioritise reporting poorer performance and this information should be provided in a form that is accessible to all stakeholders. 'Shaping culture' has been increasingly recognised as important. We describe how recent research contributes to our understanding of how cultures might contribute to quality, innovation and performance, and how engagement and particular techniques such as 'Schwartz Centre Rounds' might support this. We outline how facilitating innovation is increasingly prioritised and how it is potentially influenced by organisational culture; we also describe how it might be stimulated by engaging leadership, but stymied by excessive monitoring.

The board priorities identified in our original review - quality and safety, innovation, productivity, population health, and equality and diversity - have retained their importance since our original review. Evidence indicates that boards in the English NHS have made some progress in prioritising these issues, but also that there is still room for improvement, both at board level and at the front line. Organisational culture and staff wellbeing may have particularly important relationships with quality of care. We suggest that ongoing engagement with staff, patients and the public might support further progress in delivering on these priorities.

Throughout this section, we note that in the context of NHS Foundation Trusts the role and potential contribution of governors to board governance has grown significantly. We also note that, so far, progress in this area has been limited and we outline potential benefits of boards empowering their governors through greater engagement and training.

3.1 Formulating strategy

Most of the recently published guidance confirms the broad principles of formulating strategy outlined in our original review. However, in some cases the emphasis has shifted.

Central to recent recommendations on providing high quality care is that patients' interests need to be prioritised in all NHS boards' work (National Quality Board, 2011, Francis, 2013). The revised NHS Constitution reflects this, with the principle 'NHS services must reflect the needs and preferences of patients, their families and their carers' (Department of Health, 2008) replaced with 'The NHS aspires to put the patient at the heart of everything it does' (Department of Health, 2013b); in addition, the list of NHS values has been brought forward to sit next to 'NHS Principles' and within, the value 'working together for patients' is now the first value listed (Department of Health, 2013b).

Recent research and guidance emphasise the importance of balancing national and local priorities in board strategy (Storey et al., 2010b, Institute of Chartered Secretaries and Administrators, 2011).

Stakeholder engagement is now more strongly emphasised. We describe this in detail in later sections of this review (see Section 4.3), but it has particular relevance to formulating strategy: guidance now recommends that all stakeholder groups (staff, patients, community) are involved in identifying strategic choices and agreeing a way forward (Francis, 2013). In the case of NHS Foundation Trusts, the Council of Governors will have a strengthened role (Monitor, 2012a). In terms of organisational direction, governors must approve whether private care activity interferes with the organisation supporting NHS work and other functions, and any increases in non-NHS income of 5% or more; in future, governors will have to approve any significant transactions, any application for a major organisational change (such as a merger, acquisition or dissolution), and any amendment to the organisation's constitution (Monitor, 2012b). However, recent research on Foundation Trusts indicates that governors are not as yet supported to engage in strategic discussions of this kind, and recommend that boards should seek to better empower, inform and engage governors (Ocloo et al., 2013, Wright et al., 2011, Allen et al., 2012b, Allen et al., 2012a) (this is discussed further under 'Ensuring accountability' (Section 3.2) and 'Engagement' (Section 3.4)).

Our previous review noted the importance of workforce development strategy. This remains an important issue, but is now presented in a separate section (see 'People strategy' - Section 7.6).

3.2 Ensuring Accountability

Many of the processes of ensuring accountability are unchanged since our original review. However, there is now a stronger prioritisation of sharing poor results, and there is greater guidance on approaches that might facilitate accountability.

Deficiencies in information sharing were seen as central to the serious failures at Mid Staffordshire NHS Foundation Trust (Francis, 2013). Greater transparency with stakeholders (including the media (Committee on Standards in Public Life, 2013)) is recommended in healthcare and non-healthcare domains (Institute of Chartered Secretaries and Administrators, 2011, Francis, 2013).

Accountability is cast in recent guidance on standards in public life as an ongoing dialogue between the organisation and its stakeholders: it is therefore a means by which the board achieves openness and trust with internal and external stakeholders. This in turn may create a 'virtuous feedback loop': stakeholders understand the organisational vision and objectives, how well they are being achieved, and how stakeholders have contributed to these; developing such understanding and trust may increase the likelihood of further stakeholder engagement (Committee on Standards in Public Life, 2013).

Information should be presented in a way that is fair, balanced and understandable (Financial Reporting Council, 2012, Committee on Standards in Public Life, 2013): it should be 'intelligent and adaptable, not just data' (Committee on Standards in Public Life, 2013). Honest, candid communication with the public is seen as increasingly important (Francis, 2013, Institute of Chartered Secretaries and Administrators, 2011). An appropriate balance between reporting achievement and non-compliance should be provided, with matters that need to be improved given priority over those where the organisation is already compliant (Francis, 2013).

In addition to clarity about performance, boards should communicate clearly the purpose of various aspects of the organisation (Financial Reporting Council, 2012, Institute of Chartered Secretaries and Administrators, 2011). Examples of this include the roles of board members (Committee on Standards in Public Life, 2013), any conflicts of interest (Dr Foster Intelligence, 2011, Monitor, 2010a, Professional Standards Authority,

2012, Committee on Standards in Public Life, 2013) audit committee activity (Financial Reporting Council, 2012), and the organisation's governance arrangements (Institute of Chartered Secretaries and Administrators, 2011). Such transparency is identified as a valuable means of engaging with stakeholders, and increasing levels of stakeholder trust.

In terms of internal accountability, there is an increased focus on systems to support staff raising concerns about quality (National Quality Board, 2011), for example through a 'whistleblower policy' (Professional Standards Authority, 2012, Monitor, 2010b, Francis, 2013), and acting against any practices that might prevent raising of concerns (Professional Standards Authority, 2012). These principles are also supported in commentary based on research on organisational culture (Davies and Mannion, 2013). Boards should receive and analyse data on how management addresses performance issues, as opposed performance data itself: this may support boards in gaining an effective understanding of how management operates while retaining suitable distance from operational decisions (Storey et al., 2010b).

As described in our original review, risk assurance and risk management are important components of ensuring accountability (Moore, 2013, Storey et al., 2010a, Healthcare Financial Management Association, 2011). Risks should reflect strategic objectives and controls should be in place to address these risks appropriately (Healthcare Financial Management Association, 2011). The assurance framework is an important tool by which boards monitor progress against strategic objectives and identify significant risks. It should be supported by suitably robust systems that allow risk to be identified, assessed and prioritised. The framework should specify the sources of assurance (such as process and outcome data), who provides the assurance (whether the provider is internal or external, the provider's expertise and experience), and how the assurance was obtained (approach and timing of data collection). Data quality, in terms of validity, completeness and currency, should also be considered. Such systems are likely to vary from organisation to organisation, reflecting organisational context and priorities. It is the task of the Audit committee to assure the board of the assurance system's robustness. Based on this information, the board's role is then to decide what level of risk is acceptable, reflecting the organisation's 'risk appetite' (Healthcare Financial Management Association, 2011).

Alongside assurance on such matters as quality of care and productivity (Monitor, 2013), it is also now recommended that the board is suitably informed of how organisational culture is experienced by patients, staff and other stakeholders (Alimo-Metcalfe, 2012, Francis, 2013, Monitor, 2013). This may be achieved using tools, such as a 'cultural barometer', to provide assurance that the organisation has a healthy culture (Francis, 2013). However, research on culture outlined in our original review suggests such an approach should be applied with care: organisational culture is complex and multifaceted, making measurement challenging; further, efforts to change culture may bring about unintended consequences (Davies and Mannion, 2013, Scott et al., 2003a, Scott et al., 2003b).

Turning to how boards might best engage with this information, triangulating qualitative data with quantitative data is recommended as a useful way for boards to give hard data a 'reality check' and thus gain a meaningful understanding of organisational activity (Monitor, 2010b, Dr Foster Intelligence, 2010, Dr Foster Intelligence, 2011). Also, boards are warned that an excessive focus on monitoring can lead to 'managerial myopia' and distract from good strategy (Chambers et al., 2013).

In NHS Foundation Trusts, governors' role in ensuring accountability is increasing. Governors will be required to hold Non-Executive Directors to account for performance of the board, and may request that directors attend a governors' meeting to provide information on how the board performs its duties (Monitor, 2012b). These new roles reflect the potential value of governors as a support of wider healthcare regulation (Wright et al., 2011).

Recent research carried out in Foundation Trusts indicates that governors only engage with their current accountability duties to a limited degree (Allen et al., 2012a, Ocloo et al., 2013). To address this, research recommends that boards empower their governors, ensuring they have suitable levels of training and information to carry out their duties (Ocloo et al., 2013, Wright et al., 2011).

Information governance

It is of growing importance that NHS organisations use information effectively and appropriately (Department of Health Informatics Directorate, 2011). Responsibility for information governance lies with the board and should be described in the statement of internal control. All staff with access to personal data should receive annual information governance training. In support of transparency, an annual assessment should be conducted using the Information Governance Toolkit and the results published for review by regulators (for example the Care Quality Commission, local commissioners, the Audit Commission, or Monitor); also, any actual or potential loss of data or breach of confidentiality must be shared with stakeholders, for example through the trust annual report and through reporting to the Information Commissioner (Department of Health Informatics Directorate, 2011).

3.3 Shaping culture

The board role of shaping cultures was presented as one of growing importance in our original review. If anything, this has accelerated since 2010, with greater specification of what 'a healthy culture' might look like and evidence of approaches that might support its development. The Francis report noted numerous failures to put the patient first and identifies the need to develop a 'patient safety culture' across the English NHS (Francis, 2013). The recognition that culture is something most effectively addressed at a local level anticipates a central role for board leadership (Francis, 2013, Davies and Mannion, 2013).

Our original review noted that the complex relationships between board culture, organisational culture, and organisational performance required further exploration. Of note is a recent update to an analysis of the relationship between organisational culture (as assessed by senior management) and performance, applying the Competing Values Framework. The analysis confirms previous findings that the issues that are valued by particular cultures (for example innovation in 'developmental' cultures, and competitiveness in 'rational' cultures) tend to predict the domains in which organisations exhibiting such cultures will perform best. Of particular interest is that, while cultures maintained over time to an extent, overall there was a tendency for cultures to become increasingly blended. The authors note that a significant task is to shape blends of cultures that support high performance on locally prioritised issues (Jacobs et al., 2012).

In shaping culture, it is recommended that boards describe clearly what the desired culture looks like, lead by example by adopting these behaviours in all interactions and communicating this culture clearly throughout the organisation. Also, they should assess how well the culture is experienced by stakeholders, taking action where necessary (Alimo-Metcalfe, 2012, Monitor, 2013).

Reviews of effective board engagement suggest that a healthy culture promotes innovation, improvement and quality: in support of this, boards should shape a culture that is 'ready for change', featuring high staff engagement and wellbeing (Alimo-Metcalfe, 2012, Welbourn et al., 2012). Other features of readiness include staff autonomy, high social support, encouragement of active problem solving, staff who are confident in their ability to deal with change, and staff whose jobs are challenging but who feel empowered to manage them (Alimo-Metcalfe, 2012). Where culture is strong, organisational development staff should explore ways to spread this further across the organisation (Alimo-Metcalfe, 2012).

'Schwartz Centre Rounds' are a potentially useful means of shaping culture. These are regularly held meetings where a range of staff discuss and reflect on the emotional aspects of providing care. They have been independently evaluated in US and UK settings, with positive effects reported. The UK evaluation findings suggest a range of cultural benefits at individual level (for example, confidence and compassion), team level (networking, multidisciplinary working) and organisational level (reduced hierarchy, open culture, support for strategic vision, symbolism of management's care for staff wellbeing) (Goodrich, 2011).

Research on NHS Foundation Trusts suggests that governors have the capacity to influence both board and organisational culture, but that this capacity might be enhanced by strengthening the governor role, and through boards providing greater support and engagement (Wright et al., 2011).

3.4 Board priorities

Quality and patient safety

Guidance and research broadly confirm the principles related to governing quality and patient safety outlined in our original review. However, more recently published guidance has intensified the drive for quality and safety, and research has added to our understanding of how this might be achieved.

Guidance recommends that it is important that the three components of high quality care - clinical effectiveness, patient safety, and patient experience - should be recognised as parts of the same entity, and prioritised to an equal degree (National Quality Board, 2011). Boards have attended less to patient experience than to safety and effectiveness when considering quality, but the focus on experience is now growing (Dr Foster Intelligence, 2010, Francis, 2013).

Reflecting previous research on high performing organisations, recent recommendations now suggest quality and safety should be the principal focus of strategy (Francis, 2013) and business plans (National Quality Board, 2011). A recent analysis of surveys of US and English boards indicates English boards are more engaged with quality than their US counterparts, though there is still room for improvement. Boards of NHS Foundation Trusts performed better than those of non-Foundation Trusts, for example in terms of reviewing quality data regularly and using this to support improvement, through feedback and incentives (Jha and Epstein, 2013). Board discussions of quality should take place near the beginning of the meeting, and should be substantial (Alimo-Metcalfe, 2012). Quality information discussed by the board should draw together information from a range of sources, combining soft and hard data (Alimo-Metcalfe, 2012). Information - for example in terms of quality dashboards - should be regularly challenged and reviewed. Indicators should reflect the full range of services provided by the organisation (National Quality Board, 2011). Learning from complaints should be fed into training and induction programmes (National Quality Board, 2011).

Cultural enablers of patient safety include positive attitudes to change and innovation, a willingness to question, high trust staff relationships and positive attitudes to learning and sharing knowledge (Charles et al., 2011, Welbourn et al., 2012). Many dimensions of staff experience interact in terms of their effect on performance (for example, emotional exhaustion reduces the benefits of job satisfaction), and organisational climate has been identified as an important mediator, where a strong patient safety climate (the extent to which patient safety is prioritised throughout the organisation) strengthens the beneficial effects of wellbeing (Maben et al., 2012).

Active communication is identified as important: quality activity and decisions should be explicitly tied to strategy and communicated with staff and stakeholders (National Quality Board, 2011). As mentioned elsewhere, it is important that both successes and failures on quality performance are communicated clearly with stakeholders (Francis, 2013).

Presenting performance indicators to staff may align staff with organisational priorities and support quality and safety improvement (Atkinson, 2006, Freeman, 2002, Palmer, 1997, de Vos et al., 2013). However, these should be adapted to local contexts by involving local stakeholders (De Vos et al., 2009, Freeman, 2002) and are best used formatively in conjunction with qualitative data, to guide discussions of local improvement (Freeman, 2002).

Reviews of the evidence from healthcare and non-healthcare settings suggest positive associations between staff wellbeing and patient experience (West et al., 2010, Maben et al., 2012, Woodrow and Guest, 2013). Research on workplace bullying suggests that human resource managers in the NHS often lack the authority to implement good HR practice (Guest and Woodrow, 2012); this suggests that board leadership may be required, for example by ensuring workforce issues are an organisational priority, and by shaping an open and supportive culture where staff feel empowered to raise concerns.

To support patient centred care, research recommends that boards put effective systems in place to obtain high quality patient and public feedback, ensure staff have opportunities to engage with patients and relatives about their experiences of care, ensure there is suitable ward level leadership and support, and ensure there is sufficient staff capacity to provide these levels of care and engagement (Maben et al., 2012).

Information on the relationship between board composition and quality and safety is presented under 'board composition' (Section 7.3).

Innovation

Recent guidance describes innovation as 'sensible risk taking' (Committee on Standards in Public Life, 2013). The English NHS constitution features several commitments to innovation, for example in support of improving standards of healthcare and improving people's lives (Department of Health, 2013b, Department of Health, 2013a). Research suggests that innovation should be purposeful and not 'innovation for its own sake' (Alimo-Metcalfe, 2012).

Heavy monitoring of an organisation may limit innovation (Chambers et al., 2013) and boards should ensure they balance risk aversion and innovation (Welbourn et al., 2012). Risk aversion may be driven by external factors, such as the media (Committee on Standards in Public Life, 2013).

High levels of engagement are associated with high levels of innovation (Welbourn et al., 2012). Engaging board leadership may support innovation through activities such as 'marketplace' and 'dragon's den' style events are recommended as useful stimuli (Alimo-Metcalfe, 2012).

Recent healthcare research (Jacobs et al., 2012) and a review of non-healthcare literature (Büschgens et al., 2013) using the Competing Values Framework confirm previous research suggesting that organisational culture influences innovation. The review concludes that a flexible, externally oriented culture is most likely to be associated with innovation, but a corollary of this is a potentially unattractive loss of stability (Büschgens et al., 2013).

Population health

Population health remains an important priority (The King's Fund, 2012). As described in our original review, it is important that boards have an awareness of local needs through effective intelligence. For example, the English Department of Health's response to the Francis report notes the importance of local Health and Wellbeing Boards in improving population health (Department of Health, 2013c). Also, as outlined elsewhere, ongoing dialogue with and engagement of the public (see 'Ensuring accountability' (Section 3.2) and 'Engagement' (Section 4.3)) may encourage greater ownership of organisational priorities and services, and the public health message. This effect is potentially stronger in NHS Foundation Trusts, where the governance structure might give the public a greater sense of ownership, though research indicates some progress remains to be made in this setting (Ocloo et al., 2013, Wright et al., 2011, Allen et al., 2012b).

Resource management and productivity

Analyses conducted both before and after our original review note the existence of a significant 'productivity gap' in the NHS and the need to reduce variation and waste (Appleby et al., 2009, Appleby et al., 2010, Department of Health, 2011).

Chambers et al's recent review suggests that, despite exceptions mentioned elsewhere, there is limited empirical evidence on the relationship between board composition and organisational performance (Chambers et al., 2013).

Productivity is influenced by a number of workforce issues (West et al., 2010, McKee et al., 2010, Boorman, 2009, Appleby et al., 2011, Committee on Standards in Public Life, 2013). Staff turnover is identified in a review on engaging boards as a major cost to organisations (West et al., 2010). Research suggests HR practices, including staffing, training, and sophistication of performance appraisal, are associated with productivity (McKee et al., 2010). Boards may support improved productivity through supporting robust management, performance benchmarking, and engagement; such activities may align staff with organisational priorities and reduce absenteeism (it is noted that 70% of spending in acute and mental health trusts comprises cost of staff) (Appleby et al., 2010). However, research on productivity recommends that boards be aware of the need to balance a drive for productivity with the risk of staff burnout (Maben et al., 2012).

Equality and diversity

The need for organisational awareness and support of equality and diversity identified in our original review remains. Most recently, it is set out in the new English NHS Constitution (Department of Health, 2013a), the UK Government's Equality Act (Department of Health, 2010) and corporate guidance (Financial Reporting Council, 2012, Financial Reporting Council, 2011).

A recent report on gender diversity in corporate governance notes progress in increasing the proportion of women on boards of FTSE 100 companies to 15.6% in 2012, but that this falls short of previous recommendations that boards should aim to achieve 25% women on boards by 2015 (Davies, 2012).

Evidence on the potential benefits of board diversity is now discussed under 'Board composition' (Section 7.3).

4 Building blocks of governance

The building blocks of governance outlined in our original review - context, intelligence, and engagement - remain foundations of effective board governance. The principles underlying these building blocks are broadly unchanged, though guidance and research suggest a number of lessons that develop understanding of how these should be used.

For example, evidence suggests that external context, such as the ways in which the English NHS is re-organised, represents significant challenges to boards, but those that foster a supportive and open culture may harness these changes to encourage innovation. Intelligence remains important, but it should be effective and accessible, drawing together qualitative and quantitative data: to support effective flow of information, designation of a board level Chief Information Officer is recommended. As mentioned in previous sections, engagement of stakeholders - patients and the public, staff and partner organisations - has increased in prominence since our original review. Approaches to and potential benefits of engagement - for example in terms of ensuring public relevance of organisational objectives and staff wellbeing - are described.

4.1 Context

While the context in which NHS organisations sit has changed substantially, the nature of context's influence and how boards might best engage with it has changed less.

Storey et al's research emphasises the importance to boards of clear lines of external accountability, noting that increased complexity in external governance arrangements increases the risk of weakened accountability, as gaps or overlaps emerge (Storey et al., 2010b).

Reviews of the evidence suggest organisational uncertainty and wider turbulence are significant challenges, but also opportunities. Citing examples relating to patient safety and infection control, recent research on patient safety culture suggests value in boards harnessing external pressures to encourage innovative behaviours. However, for this to succeed a supportive, collaborative and open culture is required to avoid excessive stresses (Charles et al., 2011, Welbourn et al., 2012).

4.2 Intelligence

Again, the broad principles relating to intelligence have not changed substantially since our original review was written. However, survey research on board activity in the English NHS suggests limited awareness: board members tend to overestimate significantly organisational performance on quality and safety (Jha and Epstein, 2013). Recent research on NHS Foundation Trusts indicates that trust members are a potentially valuable source of intelligence (Allen et al., 2012b).

In line with previous research, the Francis report recommends prioritisation of quality-related intelligence as a means of supporting a quality focused organisation (Francis, 2013, Department of Health, 2013c).

The sheer volume of information presented to the board - 'voluminous routine reports which fail to tell the story, lack analysis and insight' (Storey et al., 2010b) - might militate against directors adopting a suitably challenging stance (Chambers et al., 2013). An approach to ensuring data tell a useful and accessible story is to combine hard numbers with qualitative information (National Quality Board, 2011, Davies and Mannion, 2013, Monitor, 2010a).

To ensure suitable flow of information throughout the organisation and with external stakeholders, it is recommended that a board member should be designated Chief Information Officer (Francis, 2013).

4.3 Engagement

Our previous review addressed the value of stakeholder engagement and approaches by which it might be achieved. However, recent guidance and research suggests there is more that may be done.

The potential benefits of engagement are presented clearly in research, in terms of greater innovation, quality outcomes, and staff satisfaction and retention (Welbourn et al., 2012). However, recent surveys of English NHS board members found that respondents tended not to prioritise public involvement as highly as some other priorities, such as clinical effectiveness, patient safety and financial performance (Institute of Chartered Secretaries and Administrators, 2011, Jha and Epstein, 2013). Supporting people to report bad news has emerged as potentially important: examples include prioritisation of 'whistleblower' policies and active engagement with complaints from patients, staff, and the public (Francis, 2013, Department of Health, 2013c). In NHS Foundation Trusts, governors will have a duty to represent the interests of the trust and the public (Monitor, 2012b). Overall, boards should attend closely to contextual factors when considering their approach to stakeholder engagement.

Engaging patients and the public

Our previous review noted that, while engagement of patients and the public is encouraged, there is a risk that such activity can sometimes be something of an 'add on' - and certainly, recent surveys cited above appear to confirm that involvement is not integral to board activity (Institute of Chartered Secretaries and Administrators, 2011, Jha and Epstein, 2013). Research and guidance recommend increasing meaningful board engagement with patients and the public (Francis, 2013, Department of Health, 2013b, Institute of Chartered Secretaries and Administrators, 2011, Dr Foster Intelligence, 2010, Allen et al., 2012a, Department of Health, 2013c).

Engagement may take the form of involving patients and the public in identifying strategy and service redesign (Dr Foster Intelligence, 2010). Boards are recommended to use a number of approaches to engage with patients and the public, including face to face interaction, engaging with video diaries, participating in ward rounds and shadowing frontline staff (Monitor, 2010b, Monitor, 2013, Alimo-Metcalfe, 2012, Department of Health, 2013c). Research on public health governance suggests that care should be taken to ensure suitable representation of stakeholder groups (Marks et al., 2011). Patient feedback is an important tool - both in terms of measuring performance (Monitor, 2010b, Monitor, 2013, Dr Foster Intelligence, 2010), but also as a means of marketing the organisation (Dr Foster Intelligence, 2010). A patient forum is recommended in guidance as a common and useful way to facilitate patient feedback and encourage engagement (Monitor, 2013). Foundation Trusts have additional means of involving patients and the public, including public governors and trust membership. However, research indicates that there is still room for improvement, for example in terms of ensuring suitable engagement in decision making and in sharing information on organisational performance (Allen et al., 2012b, Ocloo et al., 2013, Wright et al., 2011).

Importantly, guidance recommends that involvement is an ongoing process: once patients and members of the public have been involved or consulted, they should be informed of the outcome of the process in which they have been involved (Monitor, 2013).

Engaging staff

Recent research has identified the value of engaging staff, in terms of performance, innovation, alignment with quality improvement activity, and culture. A recent review presents research indicating that higher levels of engagement are associated with better performance on quality of care (for example, patient mortality is significantly higher in organisations with low staff engagement than those with high engagement), patient satisfaction, staff attendance, and finance (West et al., 2010). However, some research has indicated that frontline staff do not feel connected to the board, pointing to imposition of centralised solutions that do not fit with the realities on the ground (Storey et al., 2010b).

Making the board more accessible to staff may also be useful. Research recommends the potential value of formalising opportunities for staff to present findings and ideas to the board, for example in terms of quality improvements and innovation (The King's Fund, 2012) or by encouraging clinical leaders' participation in board meetings and the quality committee (Monitor, 2013).

Research on board engagement suggests that in larger organisations there may be value in varying location of board meetings. This may ensure accessibility of board meetings to a wider range of staff and stakeholders and provide further opportunities for board members to engage directly with staff and patients in a wider and more representative range of settings (Alimo-Metcalfe, 2012).

In terms of systems to support staff engagement, a review suggests staff are significantly more engaged if they receive a well-structured appraisal (featuring clear objectives and leaving the individual feeling valued by the organisation) than if they receive a poorly structured appraisal, or no appraisal at all; in addition, a poor appraisal is (very slightly) worse for staff engagement than receiving no appraisal (West et al., 2010).

Research on NHS Foundation Trusts suggests that staff as yet are not engaging fully with governance structures (Allen et al., 2012a). Challenges remain in ensuring that staff governors feel suitably engaged in their role, and not constrained by their employee status (Allen et al., 2012b).

Evidence recommends that Boards should encourage staff at all levels of the organisation to develop and demonstrate engaging leadership (Welbourn et al., 2012). Developing opportunities where staff might reflect on and analyse care provided to patients may be of value in creating a culture of engagement. For example, encouraging process analysis/Lean thinking techniques, where clinicians and managers collaborate to analyse patient journeys, may support learning and identification of performance measures that are 'owned' at the front line (Storey et al., 2010b). Schwartz Centre Rounds (described under 'Shaping Culture' (Section 3.3)) use a similarly reflective approach to build staff culture and provide a valuable opportunity for board members to engage directly with staff (Goodrich, 2011).

Engaging partner organisations

Engaging partner organisations remains an important task for Boards. A review of NHS staff wellbeing recommends that improvements to staff health and wellbeing should be developed in partnership with unions (Boorman, 2009). Research on whole system governance suggests boards should embrace the prospect of engaging with a wide range of diverse (public, private and third sector) organisations as an opportunity to foster greater innovation: 'diversity is non-optional' (Welbourn et al., 2012).

Recent research on service reconfiguration provides useful insights on stakeholder involvement in general. Boards should not assume that stakeholders will be engaged with decisions about organisational or service change simply because a certain amount of consultation has been conducted and the 'right' evidence has been presented. Contextual factors - for example the interplay between partner organisations, local politicians, the media and the general public - are likely to be influential. Therefore, it is important that boards attend closely to this layer of complexity when considering their approach to engagement (Fulop et al., 2012).

5 Individual board roles

The roles of NHS provider board members have, overall, changed little since our original review was written. However, the available research evidence has grown. Also, there has been a recent recommendation that only 'fit and proper' people should be permitted to be executive and non-executive directors, potentially reflecting individuals' experience, competence and ethics, and that this should be supported through training and evaluation (Francis, 2013).

Therefore, the sections below will focus only on where roles have altered in guidance and how research might guide our understanding of individual board member contributions. One theme that emerges strongly is how particular board members might develop their skills and activities to support greater effectiveness of the board as a whole. Another is that both Chair and CEO have roles to ensure that executive directors contribute fully to the culture of a unitary board.

5.1 Chair

Evidence from non-profit organisations suggests a chair's interpersonal skills may be important: chairs who exhibit fairness, openness to ideas, a focus on high quality relationship building and encouragement of teamwork are perceived by 'key actors' (Chief Executive Officers, other board members, staff and volunteers) as having a high level of influence on board effectiveness (Cornforth et al., 2010).

Effective chairs make use of their emotional intelligence, features of which include: social awareness, an ability to manage relationships and being service motivated (Cornforth et al., 2010).

Chairs should use both formal and informal interactions as a means of understanding board members: knowing the individuals is thought to support more effective chairing of meetings, through knowledge of how different members contribute most effectively (Deffenbaugh, 2012). Research on board dynamics notes that the Chair should ensure that Executive Directors do not stay within their specialist silos, but rather act as full members of the unitary board (Deffenbaugh, 2012).

5.2 The Chief Executive Officer

In our original review, board governance challenges related to the 'entrenched' Chief Executive Officer (CEO) were described, as was the brevity of CEO tenure (Hoggett-Bowers, 2009, Ramsay et al., 2010). Recent research and guidance suggest potential benefits of CEO longevity (Francis, 2013, Chambers et al., 2011). An analysis of a sample of NHS organisations reported that trusts classified as 'high performing' are more likely to have a CEO who has been in post for four years or longer (Chambers et al., 2011), though causal direction is not explored in the analysis. Also, a substantial qualitative study of contextual factors influencing organisational performance suggests that CEO continuity is associated positively with quality of care, staff engagement, and organisational resilience and flexibility (McKee et al., 2010). A recent US study found that hospitals with a physician CEO performed significantly better on quality indices relating to cancer, digestion and heart care than those with CEOs whose background was purely managerial (Goodall, 2011).

In facilitating an open and transparent board culture, a review of board dynamics notes the CEO has an important role in ensuring that the Executive Directors do not make a habit of presenting a united front in board discussions: it is suggested that encouraging board members to share their diverse views increases the likelihood of an open and honest debate, and a final position that is owned by the whole board (Deffenbaugh, 2012).

5.3 Non-Executive Directors

Updated guidance for NHS Foundation Trusts has reduced from nine years to six the point beyond which Non-Executive Directors are subject to annual re-election (Monitor, 2010a).

Research on boards indicates that Non-Executive Directors have a positive influence on resource use in settings where they wield influence, but that at the time of data collection business matters had won out over quality; the analysis recommends that, if given similar influence over quality, Non-Executive Directors might offer similar organisational benefits (Storey et al., 2010b). Recent NHS Foundation Trust guidance notes that governors hold the board to account through Non-Executive Directors (Monitor, 2012a, Monitor, 2013); also, it is recommended that one Non-Executive Director should have designated responsibility for overseeing the complaints system and ensuring all board members review a sample of complaints (National Quality Board, 2011). These additional quality roles, coupled with the increasing prioritisation of quality as the marker on which boards are predominantly assessed overall (Francis, 2013), represent opportunities for potential benefits of Non-Executive Director leadership on quality to be realised.

It is recommended that Non-Executive Directors should ensure they have a suitable understanding of the organisation by engaging with services at the front line. NHS Foundation Trust guidance suggests that such informal engagement might be best achieved through creating formal links, for example by attaching each Non-Executive Director to a named Executive Director and by creating formal links between Non-Executive Directors and identified wards, thus personalising staff access to the board (Monitor, 2013).

5.4 Executive Directors

NHS Foundation Trust guidance notes that in high performing organisations Executive Directors dedicate time and effort to engaging effectively with governors, for example by attending Council of Governors meetings (Monitor, 2012a).

5.5 The Senior Independent Director

As described in our original review, the Senior Independent Director (SID) remains an important figure, supporting relationships within the board and between the board and external stakeholders. In Foundation Trusts, the SID is appointed by the board in consultation with the Council of Governors; it is also recommended that the SID should be open and accessible to the governors to maximise the benefit of their insight (Monitor, 2012a).

6 Board committees

The purpose and function of board committees remains broadly unchanged since our original review. We describe where the functions of committees have developed; we also present evidence on the extent to which boards in the English NHS now have a Quality Committee.

A recent review of healthcare board performance suggests that Non-Executive Directors have a more extensive and supportive influence in board committees in the healthcare setting than in the private sector, and that board committees act as safe environments in which to ask searching or challenging questions (Chambers et al., 2013). As mentioned elsewhere, it is an important leadership role for the Chair that board members engage with the principles of the organisation's governance structures and that there is a suitable degree of respect between Executive and Non-Executive Directors. Research suggests that variations in how board committee structures are organised reflect the strong influence of Chairs and CEOs (Storey et al., 2010b).

6.1 Audit committee

The Audit Committee supports the board's strategic work by critically examining governance and assurance processes, providing assurance on the Assurance Framework and any public statements that are derived from the assurance system. In the healthcare setting, the committee's remit should cover clinical, financial and operational risks, to support effective risk management and internal control. In reviewing the assurance framework, the Audit Committee should assess whether objectives are suitably strategic and clearly defined, whether all relevant groups have been consulted, and how well they are shared across the organisation. (Healthcare Financial Management Association, 2011).

In Foundation Trusts, it is recommended that at least one member of the Audit Committee has recent and relevant financial experience (Monitor, 2010a). The Council of Governors appoints the external auditor (Monitor, 2012a, Monitor, 2012b).

6.2 Remuneration committee

In the context of NHS Foundation Trusts, guidance recommends that the Council of Governors sets remuneration of the Chair and Non-Executive Directors. To ensure an appropriate level of remuneration is offered, external professional advice should be sought at least every three years, or in the event that a change in the terms of remuneration is under consideration (Monitor, 2012a).

6.3 Quality committee

Reflecting evidence described in our previous review, quality committees are now recommended in NHS Foundation Trust guidance (Monitor, 2013). A recent survey suggested a high proportion of Foundation Trusts (91%) and non-Foundation Trusts (84%) have such a committee. A review of board performance concludes that higher performing organisations are more likely to have a quality committee (Chambers et al., 2013), although as a higher proportion of NHS organisations come to have a quality committee, this distinction becomes less useful.

6.4 Nominations committee

Guidance recommends that when selecting Non-Executive Directors in NHS Foundation Trusts there should be a majority of governors both on the committee and on the interview panel (Monitor, 2010a).

7 Building board effectiveness

Many of the main features of boards remain broadly unchanged since our original review. Research has provided some useful lessons on how these might contribute to high quality board governance.

Research indicates that board composition, in terms of clinical background and proportion of women, might positively influence board effectiveness. In terms of process, it is recommended that effective boards prioritise quality and safety and ensure monitoring does not supplant strategy, but survey and observational research indicate that boards as yet prioritise neither sufficiently. Board culture is still regarded as a pivotal issue. However, the factors influencing this are as yet not well understood, and it is possible that structure and composition do exert an influence on culture.

Following recent guidance and research, 'people strategy' is now identified as an additional feature of board effectiveness, reflecting how boards need to support the development of future leaders and engage with staff to ensure a healthy workforce overall.

The relationship between board characteristics and leadership effectiveness is complex, and heavily influenced by context: a 'one size fits all' mind-set is unlikely to be useful. Also, what boards do - as reflected in processes and dynamics - is likely to be at least as important as their more structural features. However, more research is needed in order to gain a clear understanding of these complex relationships.

7.1 Structure

Recommendations in UK guidance on overall board structure (Financial Reporting Council, 2012, Monitor, 2010a) remain broadly unchanged since our original review. There is still little in the way of conclusive evidence on the optimal board form (Chambers and Cornforth, 2010, Chambers, 2012).

Chambers et al note the potential for future research to examine different governance forms in the current English NHS, comparing and contrasting the unitary structure of NHS Trust boards with that of NHS Foundation Trusts (Chambers et al., 2013). In Foundation Trusts, the unitary board is tied to a Council of Governors: this is variously described as approximating the two tier approach of many countries in mainland Europe (Chambers et al., 2013) or approaching the style of governance associated with social enterprises (Veronesi and Keasey, 2012).

Recent research indicates a positive association between Foundation Trust status and a healthy approach to governance. Jha and Epstein's survey of English NHS board leaders revealed that boards of NHS Foundation Trusts were significantly more likely than boards of NHS Trusts to review Healthcare Associated Infections, medication errors and staff experience on a monthly basis, and to use performance data to provide feedback and financial incentives to staff (Jha and Epstein, 2013). Also, recent qualitative research found that participating NHS Foundation Trust boards demonstrated greater levels of engagement of staff and other stakeholders, reflected in such activities as strategy development, monitoring and reporting progress internally and externally. In turn, these organisations were found to be the highest performing on measures of service quality and financial management (Veronesi and Keasey, 2012).

Causal direction is an important consideration in investigating such findings. There is thus potential value in conducting in depth qualitative research to further explore factors influencing board governance processes, and how these relate to organisational performance at process and outcome level.

7.2 Size

Recent guidance has not recommended any changes in the size of NHS provider boards. As in our original review, research-based recommendations on board size still vary (Bennington, 2010). There is limited evidence suggesting that smaller boards may be more effective. However, a review of the evidence on board performance indicates it is likely that the number of directors on a board is rather less important than what directors do (Chambers et al., 2013).

7.3 Composition

Research evidence indicates that there may exist a connection between board composition and organisational strengths. However, a contingency perspective is emphasised: certain board compositions may better suit different challenges. For example, boards with a higher proportion of independent directors may support minimisation of risk in an organisation; smaller boards with more 'insiders' may support more innovation; while a larger proportion of 'boundary spanners' may support legitimisation of a new organisation with partner organisations (Chambers et al., 2013).

Our original review noted the potential value to healthcare boards of 'insider expertise'. This is reflected in the Francis Report's support for a stronger nursing voice, for example recommending that boards obtain and record the Director of Nursing's advice on how nursing staffing arrangements might impact on quality of care, and that boards should be encouraged to recruit nurses as Non-Executive Directors (Francis, 2013). In terms of research, a recent study indicates that a higher proportion of doctors (but not other clinicians) on boards is significantly associated with improved patient satisfaction and reduced mortality (Chambers et al., 2013, Veronesi et al., 2012). Also, research suggests that CEO characteristics may be important, with background as a doctor associated with better levels of quality in US hospitals (Goodall, 2011) and CEO tenure supporting prioritisation of patient safety in UK hospitals (McKee et al., 2010). The tendency to select doctors for a board role based on their clinical, rather than governance, expertise is noted (Bennington, 2010). Given doctors' potential contribution to board and organisational effectiveness, this suggests that induction and training is particularly important with this staff group.

There is some research evidence on the benefits of diversity. Reviews of the evidence indicate that greater gender and race diversity at board level is positively associated with greater innovation (Bennington, 2010). Research indicates that training in equality and diversity is associated with lower staff absenteeism (West et al., 2010). Boards may benefit from featuring more women. A recent study found that 'high performing' healthcare organisations were more likely than 'low performing' organisations to have a board featuring at least 50% female membership (Chambers et al., 2011). Research suggests boards featuring a higher proportion of women may perform more effectively: identified benefits include better decision making, sensitivity to other perspectives, greater transparency, and higher quality governance processes (Alimo-Metcalfe, 2012, Chambers et al., 2013, Bennington, 2010).

7.4 Skills

As described in our original review, and reflected in previous sections of the current review, boards must draw together a wide range of skills to carry out their duties (National Quality Board, 2011, Storey et al., 2010a). Many of these relate to topics under discussion in board meetings, reflecting such priorities as finance, productivity and most importantly quality (Storey et al., 2010a, National Leadership Council, 2010). Wider skills to ensure effective working of the board include decision making, people management (based on emotional intelligence), and managing numerous complex issues simultaneously (Storey et al., 2010b, Deffenbaugh, 2012, Storey et al., 2010a).

Corporate guidance recommends that Executive Directors consider taking on a non-executive role in another organisation: this may help ensure they possess a suitably wide range of board governance skills, and contribute to board dynamics by providing them with a clearer appreciation of the contributions and needs of their current non-executive colleagues (Financial Reporting Council, 2011).

7.5 Processes

A review of the literature on board effectiveness concludes that, 'board processes (the way information is gathered, knowledge is built and decisions are made) are more important than structure and composition' and cites evidence that high performing hospitals have boards that engage more strongly with governance processes such as formulating strategy and shaping a proactive and interactive culture (Chambers et al., 2013).

In line with research described in our original review, recent guidance recommends that such matters as safety, quality, and ethics should be given priority in board agendas (Francis, 2013, Committee on Standards in Public Life, 2013, Institute of Chartered Secretaries and Administrators, 2011).

As in our original review, the importance of balancing board processes is noted: a review of evidence on board performance describes the dangers of 'managerial myopia', where excessive focus on performance monitoring detracts from strategic thinking (Chambers et al., 2013).

Corporate guidance notes the potential influence of conflicts of interest, emotional attachments and reliance on incomplete information when making decisions. To mitigate these effects in the case of important decisions, a number of processes are recommended. These include providing a written description of how a proposal was developed, commissioning independent advice, and establishing a single purpose subcommittee (Financial Reporting Council, 2011).

Research and commentary on board effectiveness notes the value of board evaluations and development programmes (Chambers et al., 2013, Deffenbaugh, 2012, Storey et al., 2010a). Corporate guidance recommends that evaluation should be tailored to the board and setting (Financial Reporting Council, 2011). However, no evidence was found on how board development tools, interventions and programmes influence organisational performance, and recommended that this should be researched further, with consideration given to the influences of external facilitation and organisational context (Chambers et al., 2013).

In addition to formal evaluations, research on board engagement suggests there is value in boards reflecting on the effectiveness of their meetings, for example in terms of how the meeting has contributed to improving quality, learning and engagement (Alimo-Metcalfe, 2012).

To support the important relationship between the board of an NHS Foundation Trust and their Council of Governors, it is recommended that the board sends a copy of the board meeting agenda to the Council before the meeting takes place, and the minutes of the meeting once they are complete (Monitor, 2012a, Monitor, 2012b).

Recent survey and observational research suggests board activity may fall short of what is recommended in guidance. For example the proportion of strategic items and clinical and quality issues on agendas was found to be lower than recommended (Institute of Chartered Secretaries and Administrators, 2011), and almost 20% of boards surveyed did not dedicate over 20% of the meeting to quality and safety issues (Jha and Epstein, 2013).

7.6 People strategy

As described in our original review, boards should attend to workforce issues in their strategy. Recent guidance suggests effective boards recognise their workforce as their greatest resource (Chartered Institute of Personnel and Development, 2012) and that 'exploiting passion' of staff may be beneficial (Francis, 2013). Guidance and research suggest that 'talent management' - developing future leaders from within the organisation - is a central focus of successful boards (Chambers, 2012, Veronesi et al., 2012, Financial Reporting Council, 2011). For example, the potential value of doctors as executives identified in US research (Goodall, 2011) implies the need for a strategy that ensures sufficient development and training programmes are in place, and which incentivises clinical leadership (Financial Reporting Council, 2011, Veronesi et al., 2012).

Research on board engagement, organisational culture and human resources describe the potential harm of stress in the workforce (The King's Fund, 2012, McKee et al., 2010). A review of staff wellbeing recommends that wellbeing should be championed at board level, and that strategies should be in place to improve the health and wellbeing of the workforce. These strategies should be adapted and added to reflect local workforce need (Boorman, 2009). Research on human resource management suggests that setting clear goals that are understood at every organisational level is a predictor of higher patient satisfaction (West et al., 2010). As mentioned elsewhere (for example Section 3.4), staff wellbeing is associated with quality of care and productivity and can be supported through such processes as well structured appraisal, suitable staffing levels, training, particularly when provided within a patient safety-oriented culture (McKee et al., 2010, West et al., 2010). This may support a 'spiral of positivity', where staff commitment to the organisation is reflected in patient outcomes and patient satisfaction (West et al., 2010).

7.7 Culture and dynamics

While board culture and dynamics are increasingly recognised as important, the related lessons on board culture and dynamics presented in our original review are broadly unchanged.

As described throughout this review, board culture has been a focus of recent healthcare guidance and research (Chambers et al., 2013, Department of Health, 2013c, Francis, 2013).

Features of a healthy board culture include high trust between members (Chambers, 2012) and capacity to have open and constructive debate (Deffenbaugh, 2012). Board members' emotional intelligence is identified as important (Chambers et al., 2013, Cornforth et al., 2010). This may support better chairing of meetings and management of relationships (Cornforth et al., 2010).

A review of research on engaging boards suggests that a useful activity in strengthening board culture is to spend time together away from the boardroom, for example in terms of attending development days, but also in social settings (Alimo-Metcalfe, 2012).

While the factors that influence how boards make the decisions they make are clearly important, they are as yet not well understood. The need for more research, ideally using observational methods, is identified (Bennington, 2010, Chambers et al., 2013).

8 Conclusions

This review was commissioned to support development of the updated guidance, The Healthy NHS Board 2013: Principles for Good Governance. As with our original review, we aimed to bring together lessons from guidance and research that might support effective board governance. This information was drawn from healthcare and non-healthcare domains, with an international scope and a particular focus on the English NHS.

Although this review is not exhaustive, we found much guidance and research to enhance our appreciation of the roles and duties of boards and our understanding of how they add value to the organisations they lead. Based on this information, we have identified lessons that we hope will be of use to NHS board members.

Evidence and guidance on board roles and the building blocks of effective governance have increased since our original review was published. Our updated review suggests that certain issues have gained prominence since 2010, notably the prioritisation of the quality of care and the increasing extent to which stakeholder engagement is valued. Also, in the context of NHS Foundation Trusts, the developing role of governors has relevance to many aspects of board governance.

In our original review, we noted that there were several domains in which we could not draw firm conclusions. For example, associations have been found between board characteristics, board activity, organisational behaviour, and aspects of quality and performance. However, the nature and direction of causality in these associations frequently remains unclear. To reach an understanding of these important matters, further research is required.

Writing this addendum to our original review has provided us with an opportunity to engage with a wide range of research and guidance on how boards govern and add value to the organisations they lead. We hope this represents a useful contribution to refreshed guidance that will continue to support the important roles played by NHS boards.

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