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HEALTHY BOARDS FOR A HEALTHY LONDON



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HEALTHY BOARDS FOR A HEALTHY LONDON

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This guide was written as part of a development programme from Leading for Health, the leadership arm of NHS London, and is published on their behalf.

October 2010

HEALTHY BOARDS FOR A HEALTHY LONDON

Chapter 1: The board's three key tasks	1
Chapter 2: What really matters	9
Chapter 3: Reviewing you and your board	27
Chapter 4: Governing for quality and safety	37
Chapter 5: Strategy and the role of NHS boards	49
Chapter 6: Governing in an age of austerity	59
Appendix: Where to go for more	69

I'm delighted to launch Healthy Boards for a Healthy London. This publication comes from Leading for Health, the leadership arm of NHS London, which is tasked with delivering practical leadership development solutions for health services across the capital. In a time of financial and organisational upheaval, never has it been more important for boards to be effective. The guide delivers targeted support for board members in this particularly challenging period.

Research has shown that successful boards excel at listening to their stakeholders and show clarity in their decision making and the actions they take. Furthermore, they demonstrate accountability to the public and a willingness to develop and learn. This leads to improved and more user-friendly services to patients.

There are many boards in London achieving this against a backdrop of profound transformational change.

The guide examines that experience and translates it into case studies. These reflect real life, and create opportunities for reflection and development.

Complementing the work of the National Leadership Council, the guide includes contributions from over 80 individuals from within the NHS, academia and the public and private sectors.

Designed to be dipped into rather than read at one sitting, I hope board members, both newly appointed and more experienced, will find it helpful in dealing with change and a valuable resource in board development.



Sir Malcolm Green, Chairman, Leading for Health

INTRODUCTION

The purpose of NHS boards in London is to build public and stakeholder confidence and ensure accountability (National Leadership Council, 2010) To provide the necessary leadership, board members should know:

- what good practice governance involves
- how to promote effective governance.

This chapter deals with the first of these by defining the board's three key tasks:



1. gaining insight
2. clarifying priorities and expectations
3. holding to account.

1.1 GAINING INSIGHT

To govern effectively, a board needs to gain insight. This means understanding:

- what patients, the public, commissioners and government want from the organisation
- stakeholders' experiences of the organisation
- whether the organisation has the capacity, capability and culture to deliver what stakeholders want.

Members of NHS boards in London should work to understand:

- their own board's strengths and weaknesses
- their local population – its demographics, diversity, and current and future needs
- likely developments in NHS policy, especially in response to current and future economic pressures
- the implications of Academic Health Science Centres (AHSCs) on the services provided and/or commissioned by their organisation
- the clinical services provided and/or commissioned by the organisation, including what patients and carers think about those services

'Chairing an acute NHS hospital is akin to chairing a large and complex business – with above average risk. The key to success is meeting, or preferably exceeding, your customers' expectations.

Felicity Goodey, CBE, DL, Chairman, University Hospital of South Manchester NHS Foundation Trust, Businesswoman who led 'The Lowry', Britain's Millennium project for the Arts.

'Equality and Diversity does not 'belong' to any one single director on the board. It is the combined responsibility of every single member of the board to include, to involve and to represent the interests of all of the diverse population that they serve. Where these interests are not being met, it is the role of the board to challenge and to ensure that improvements are made and that commissioning for Equality and Diversity is core business'.

Pamela Brown, Equality and Diversity Specialist Consultant

- the local borough perspective
- the organisation's performance in relation to national targets and regulatory requirements
- the organisation's culture, and its capability and capacity to deliver and/or commission existing and future services
- how the medical and non-medical workforce is planned for, educated and developed
- the impact and possibilities of vertical and horizontal integration
- other opportunities and risks to the organisation.

These insights will come from various sources, including:

- market analysis, patient surveys, staff surveys and LINKs (Local Involvement Networks)
- the board's integrated performance pack, the Board Assurance Framework, internal and external audit reports
- board members' direct contact with the organisation and stakeholders.

1.2 CLARIFYING PRIORITIES AND EXPECTATIONS

In clarifying priorities and expectations, NHS boards should adopt nationally approved standards and targets, particularly in operational performance and short-to-medium term goals. These include:

- the Care Quality Commission's *Essential Standards of Quality and Care* (Care Quality Commission, 2010)
- Monitor's *Compliance Framework* (Monitor, 2009)
- the Department of Health's *Operating Framework* (published annually)
- the principles and values defined in the *NHS Constitution* (Department of Health, 2009).

However, NHS boards have some flexibility in relation to:

- defining a vision and strategic priorities for their organisation
- clarifying expectations or boundaries about how the organisation should work towards this vision
- deciding how the board itself should operate.

Defining a vision and strategic priorities for the organisation

The first priority of any NHS board is to clarify the difference it wants to make to the health and wellbeing of patients and the local population. Capital programmes, service developments and cultural transformation initiatives may help achieve this vision, but they are not the primary goal of the NHS.

Creating a vision and setting strategic priorities are explored further in Chapter 5.

Clarifying expectations about how the organisation should operate

Having clarified the strategic and operational outcomes, the board could simply step aside and let management get on with it. However, boards need to exercise caution since management could potentially use any means, including inappropriate and potentially dangerous practices, to achieve the board's priorities. The recent cases of Maidstone and Tunbridge Wells and Mid-Staffordshire Trusts (described in Chapters 4 and 2, respectively) show how the desire to become an FT can lead to an unbalanced focus on performance and finance at the expense of quality.

NHS boards should, therefore, clarify that in pursuing the priorities they have set, they expect management to:

- adopt the core values and principles in the *NHS Constitution* (Department of Health, 2009) in all decision-making and actions
- operate efficiently and productively
- create a culture of innovation and learning
- champion equality and diversity
- develop talent and proactively plan succession
- work constructively with partners.

The benefits of clarifying, communicating and monitoring expectations in each of these areas are described in *The Healthy NHS Board* literature review (National Leadership Council, 2010).

Boards should be wary of becoming drawn into doing the job of management. This slows progress to the pace of the board's decision-making and blurs accountability. The board should limit its setting of expectations to areas that materially help management achieve the board's priorities or mitigate the key risks to delivering them.

One effective approach is for the board to specify the outcomes that it does NOT want to see, for example, *'No patient will experience unnecessary pain'*, *'No member of staff will be subject to bullying and harassment in this hospital'*. Here the board is saying to management, *'Everything is permitted unless it is forbidden'*. This concept lies at the heart of most legal systems and empowers CEs and other managers by setting clear boundaries.

Deciding how the board should operate

The board should clarify its priorities and expectations in relation to its own standards of behaviours, structures and processes – for instance:

- how, and how often, it will meet
- how to structure its own governance arrangements
- what skills it needs and how new board members should be inducted
- how board members should behave
- how to communicate its priorities and expectations to the organisation and key stakeholders
- how to evaluate its own effectiveness and the contribution of individual board members
- how to clarify the boundary between the Board and the Executive
- how to carry out succession planning for all board members.

The need to clarify priorities and expectations might seem obvious, but many board members contributing to this guide said that this basic task is often missing. Furthermore, when describing the risks to the vision and strategic priorities, board members often do not describe the same set of risks and cannot explain how key risks will be mitigated. Clearly, if board members are unclear about these essential aspects of the organisation, then their staff – charged with making the board's vision and priorities a reality – stand little chance of understanding them.

According to practitioners, the best boards agree and stick to a compelling vision and a small handful of strategic priorities. They also devote a great deal of time to ensuring that staff understand them and are held accountable against them.

1.3 HOLDING TO ACCOUNT

Every NHS board is responsible for holding management to account for meeting the expectations it has set and delivering its priorities. The board itself is held to account by regulators. Commissioners will hold providers to account, and vice versa.

The board and its members hold management to account by seeking and obtaining assurances.

Assurance

All board members have a personal responsibility to assure themselves that the organisation is being well run. They should be satisfied with explanations or proposed action that they are offered. Their satisfaction comes from personal judgements they have made about the accuracy and completeness of what they are being told and/or the likelihood that a set of actions will deliver the outcomes stated.

Board members often confuse assurance (*'It is ok because I have reviewed various reliable sources of information and I'm satisfied with the course of action'*) with assumption (*'It's ok unless we have evidence to the contrary'*) and reassurance (*'It's ok because the Medical Director says it is'*).

As the board members' role is not to manage (and so they cannot directly oversee what happens in their organisation), they can never be 100 per cent assured. They can, however, be *reasonably* assured when they know several of the following are in place:

- they can rely on the quality of information presented to them because it has been tested by internal audit or external parties
- they know what they are being told is the truth and management are not covering up or misrepresenting information
- they fully understand the problem or opportunity they are addressing
- under scrutiny, a board member (usually an Executive Director) can explain clearly and logically what has happened, why it has happened and what is being done about it. One NED based in the City of London said, *'A good sign of assurance for me is whether or not, under a little probing, it is clear whether or not management know what they are talking about'*
- under scrutiny, management's explanations for events or reasons for a particular course of action by the board are consistent, both over time and between members of the management team

'If you can't explain it simply, you don't understand it well enough'

Albert Einstein

- the issue is not stuck – there is not a history of failure to sort out the problem
- the organisation has a track record of delivering something similar in the past – for instance managing change
- the problem or issue is within the gift of the board and the organisation to resolve, and is not dependent on the decisions of others
- in complex or technical areas, independent advice has been sought from appropriately qualified people
- board deliberations and decision-making have been free from bias and undue influence
- a group of 'peers' would be likely to reach a similar judgement on the basis of the same information.

When deciding whether or not they are assured, individual board members are influenced by personal factors, including:

- **professional experience** – a member with a financial background may need more evidence to be assured about the organisation's underlying financial position than a non-accountant
- **personality** – what one member sees as proper attention to detail might be perceived by another as unnecessarily picky
- **personal experience** – a member with regular experience of NHS services may reflect this experience in their questions to the board.

These personal factors are valuable, but board members should be conscious of them and that they do not unduly influence their judgements.

Holding to account

Being assured results from an internal and subjective process (exercising personal judgement), whereas holding to account describes an external activity, such as a set of questions aimed at understanding and constructively challenging what is being presented:

- *Can you provide the board with a progress report on delivering the Annual Plan?*
- *Can you tell me the reasons why we have not hit our four-hour A&E target three months in a row?*
- *What are management doing to control the overspend on prescription drugs?*

This is a key skill of every board member, whether they are an Executive or Non-Executive Director, and is explored in Chapters 2 and 3.

'Holding to account is a process of constructive challenge leading to an assurance that an individual's responsibilities have been properly met or are being actively pursued.'

*Stuart Emslie, Independent
Board Effectiveness
Consultant, 2010*

1.4 GOVERNING IS NOT THE SAME AS MANAGING

A key distinction between governing and managing is the extent to which they focus on outcomes. The board should spend most of its time clarifying and holding management to account against the delivery of outcomes. These outcomes relate both to the differences that the board wants to make (e.g. *‘Patients will report that they have been treated with dignity and respect’*) and the means by which the organisation delivers this vision (e.g. *‘The same Serious Untoward Incident will not occur more than once’*). Management, on the other hand, are more likely to focus on inputs, processes and systems in pursuit of the board’s specified outcomes.

‘In my brief experience much of the NHS seems more interested in inputs, process, and audit than it is in outcome. All of that is important but they are means to an end, not the end in itself.’

Chairman, London-based Acute Trust

Other key distinctions between governing and managing are set out in Table 1.1.

Characteristics	Board (governing)	Managers (managing)
Exposure to external stakeholders	Full	Partial
Authority/legitimacy	Drawn primarily from their interface with key stakeholders and legal constitution	Drawn from their place in the management hierarchy and expertise
Exercise of authority	A group activity unless explicitly delegated by the board	Either as an individual or group
Decision-making	Group-based unless explicitly delegated by the board	Individual or group-based
Key behaviours	<ul style="list-style-type: none"> • Debating and agreeing high-level priorities and expectations for management based upon the collective best interests of key stakeholders • Holding management to account in terms of progress towards realising agreed priorities and expectations 	<ul style="list-style-type: none"> • Setting local performance expectations for others based on the high-level priorities and expectations set by the board • Providing instruction to others about what needs to be done, and advice and suggestions about how to do it together with advice and suggestions about how to do it
Time with those that they are governing or managing	NEDs in particular will spend significantly less time than a manager in the organisation	Likely to have daily or weekly contact with those they are managing

Table 1.1 Distinctions between governing and managing

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INTRODUCTION

This chapter takes a wide-ranging look at how NHS boards can promote effective governance.

It starts by considering the findings of research into board effectiveness, and the lessons to be learnt from recent failures in financial and quality governance.

The chapter goes on to explore:

- the balance between trust and challenge in the boardroom
- the roles of the Chair, Chief Executive (CE), Non-Executive Director (NED) and Executive Director (ED)
- what makes an effective Chair/Chief Executive relationship
- the capabilities of an effective board member.

2.1 WHAT WE KNOW ALREADY

In order to determine what makes for effective board performance, we sought out examples of good – and bad – practice, by:

- conducting a literature review of recent high-profile failures of governance
- speaking to board members from the NHS, and public and private sectors
- asking experienced board effectiveness consultants.

Effective boards and organisational performance

A growing body of research provides strong evidence of a link between board effectiveness and organisational performance in the NHS. A research report for the National Institute for Health Research (2010) found that Trusts that practised effective governance made the most effective use of resources and were competent in financial management. The researchers also found an association between good governance and clinical outcomes. Similarly, Stuart Emslie (2007 and 2008), in his study of 21 NHS Foundation Trusts, found that better-performing boards of Directors are associated with higher-performing Foundation Trusts.

Failures of governance

Two major recent governance failures highlight the dangers of poor governance.

The credit crunch

Sir David Walker, in his major review of corporate governance failings in UK banks (Walker, 2009) concluded:

'Improvement in corporate governance will require behavioural change ... board conformity with laid down procedures ... will not alone provide better corporate governance overall if the chairman is weak, if the composition and dynamic of the board is inadequate and if there is unsatisfactory or no engagement with major owners'.

Many lessons learnt from the failings of boards of financial institutions have relevance to non-financial institutions. A summary of these failings is provided in Table 2.1.

Board culture	<ul style="list-style-type: none"> • No evidence of constructive challenges by Non-Executive Directors • Board structures had form but not substance, e.g. Risk Committee meeting twice a year
Board role in strategy	<ul style="list-style-type: none"> • Boards approved strategy but had no mechanisms to monitor implementation • Strategy decisions were not linked to risk
Board oversight of controls	<ul style="list-style-type: none"> • Board membership did not reflect the industry or technical expertise needed • Boards lacked knowledge about their company's technical methodologies • Board oversight of risk issues needed strengthening
Board information	<ul style="list-style-type: none"> • Information on key risks and activities not did not reach the board • Management information focused on current issues, not forward looking • Boards were unresponsive to industry reports on emerging risks

Table 2.1 Board failings in UK banks severely impacted by the credit crunch

Patient safety failures

In 2007, statistics from Dr Foster indicated a higher-than-average mortality rate at Mid Staffordshire NHS Foundation Trust; estimates of lives lost between 2005 and 2008 ranged between 400 and 1,200.

The Healthcare Commission investigation highlighted the ‘shocking’ patient care, particularly in the Emergency Department. The Trust’s previous Chairman highlighted the board’s attitude to governance:

‘There was no effective governance... very poor flow of information... very poor information... a muddled data collection... very complicated incomprehensible structures of committees... unclear which committee reported to which or what the functions were... few terms of reference’ (see case study).

Red flags of governance failure

From these failures of financial and quality governance we can produce a list of high-level indicators (‘red flags’) that indicate a board may be failing (see case study).

The Robert Francis inquiry report into the Mid Staffordshire NHS Foundation Trust (Francis, 2010) highlighted shortcomings in the following areas:

Board priorities

- narrow focus on achieving Foundation Trust status and ‘star-ratings’
- lack of focus on operational issues
- board agendas too long
- finance given priority over quality and clinical governance

Information

- information received by board not good enough to prompt informed challenge
- critical systems for monitoring patient safety informal; no associated paperwork or monitoring
- ‘accumulations’ of issues not spotted; paper-based incident reporting out of date
- complaints trends and complaints of a serious nature not brought to attention of the board
- no closure in the information loop; no resultant learning or action from incidents or complaints

Response to performance failures

- little action taken on issues raised
- 'lack of urgency' to resolve operational issues (e.g. staffing ratios in Emergency Department)
- lack of concern about poor performance in clinical audits
- board defensive on exposure of high mortality rates, blaming clinical coding process

Board structure

- disjointed board
- clear lack of challenge and accountability despite some awareness of ineffective systems, processes and governance

Lines of communication

- no ownership of governance or risk processes by Medical Director
- no direct line-of-sight from board to many important sub-committees
- staff feeling unable to raise concerns and no action taken when they did.

Reflection

Does your board show any of these high-level indicators of governance failure?

1. There is a history of shocks or issues arising 'out of the blue' at board level.

E.g. Financial position varies significantly from month to month and is inconsistent with plan.

2. There have been multiple performance failures in quick succession.

E.g. A number of serious untoward incidents have been reported.

3. Issues remain unsorted or problems deteriorate over at least 12 months.

E.g. A number of key performance targets have not been met over 12 months.

4. Staff unclear about organisational priorities or what is expected of them.

E.g. Staff survey indicates confusion about the relevance of the organisation's strategy or vision.

5. Board priorities and expectations are unaligned with the purpose of the organisation or the needs of its key stakeholders.

E.g. Out of ten board priorities, only one addresses quality and safety.

If your board is showing any of these high-level indicators, consider the help available to enable you to resolve these difficulties.

2.2 WHAT THE EXPERTS SAY

To explore further what makes for effective board governance, over 80 experts were interviewed for this guide, including the Chairman of a Premier League Football Club, board effectiveness consultants working exclusively with FTSE 100 boards and the US equivalent (Fortune 100), and Non Executive Directors (NED) from leading charities. Remarkably, in responding to an open-ended question, ‘What makes a board effective?’, they all essentially said the same things.

One Chairman said:

‘Board members need to feel that they can challenge one another. To do that there must be trust in the boardroom’.

A Non-Executive Director from the City commented:

‘The best boards have diversity of skills, knowledge and personality that are all brought out to benefit the board by a highly-skilled Chairman’.

Finally, a Partner of a professional services firm who has worked with hundreds of boards in the public and private sectors said:

‘There is a very fine line between a board being effective and not. I have seen effective boards become ineffective boards overnight. The reason for the change in most cases was the introduction of an overly-dominant board member’.

A quote by John Carver, founder of Policy Governance, neatly captures the conclusion from both our interviews and literature review. In commenting on a ground-breaking research study by Richard Leblanc and James Gillies (2005), John Carver stated:

‘They found that:

- interactive processes [board relationships]
- director characteristics [capability]
- and structure

– in that order – are important to effective governance; ironically the reverse order of their visibility to the outside world..’

In other words, board relationships and the capabilities of individual board members are critical for good governance.

'The most critical need is for an environment in which effective challenge of the executive is expected and achieved in the boardroom before decisions are taken on major risk and strategic issues.'

Walker, 2009

2.3 CHALLENGE IN THE BOARDROOM

Achieving a balance between trust and challenge in the boardroom is essential. Too much challenge – or too little – can have serious consequences.

Lack of challenge

One lesson of the recent financial and patient safety failures is an absence of effective challenge in the boardroom. The Walker Review (Walker, 2009) observed that:

'The essential "challenge" step in the sequence appears to have been missed in many board situations and needs to be unequivocally clearly recognised and embedded for the future.'

A lack of challenge at board level can occur if the board:

- is too trusting of management and clinicians
- lacks the knowledge or information to challenge on a subject (e.g. clinical matters)
- is dominated by an autocratic CE or Chair and is isolated from the outside world, including its own staff.

When these conditions are present, the result may be that:

- appropriate debate and challenge is absent, and papers go through without adequate scrutiny or debate
- there is no systematic monitoring of how key decisions are enacted
- it is unclear who is responsible for what
- management can set and pursue their own agenda, running the risk of corruption or fraud
- over time, there is a history of shocks, e.g. financial deficits and poor quality reviews come 'out of the blue'
- nasty surprises are dismissed as being based on poor evidence or are blamed on others
- good news is welcomed, but raising difficult questions is discouraged
- reassurance replaces evidence and those who raise questions are labelled as troublemakers
- a sense of arrogance develops in the boardroom.

Too much challenge

The solution is not to challenge everything. If a board is too challenging:

- the Executive may become defensive and self-protective, sharing only good news
- where there are performance issues, the board gets bombarded with an excess of data that is impossible to analyse
- covert alliances may form aiming to 'manage the agenda' in advance
- 'back channels' may be used to convey concerns to the regulators or SHA
- corporate responsibility gives way to a culture of individual blame
- board agendas become lengthy and bogged down in procedural wrangling, with minutes of previous meetings becoming a minefield
- the board may become risk-averse and innovation is stifled
- management may reluctantly share certainties with the board but, for fear of being wrong, not hunches or instincts
- only the most confident or arrogant voices get heard
- senior managers may dread presenting to boards; in extreme cases, they may suffer stress or burnout, either leaving or going off sick.

2.4 TRUST IN THE BOARDROOM

For a board to be able to challenge effectively and confidently depends on there being trust within the boardroom.

What is trust?

Trust is central to organisational success. It results from our judgements of the decisions and actions of others. With reference to NHS boards, Stanton and Bevington (2005) identified three components to these judgements.

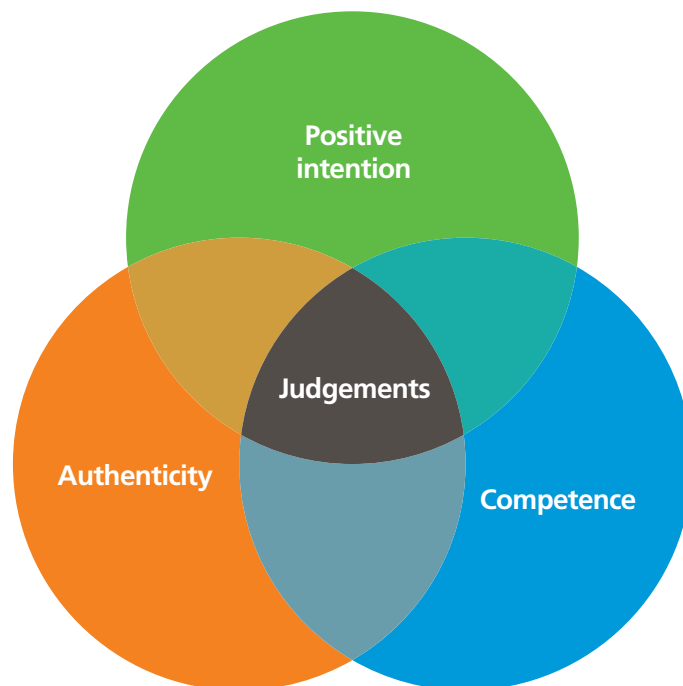
Competence – the distinctive expertise of individuals in given areas is respected and recognised by the board and those outside it.

Positive intention – board members believe their colleagues are not motivated by self-interest or hidden agendas, but operate in the best interests of the organisation (or wider public good). They can share difficult and sensitive information knowing it will not be ignored or used against them.

Authenticity – board members say what they feel and deliver on their promises.

'The most important question human beings can ask themselves is whether the world is a friendly or an unfriendly place, for their answer to that question determines whether they spend their lives building bridges or building walls.'

Albert Einstein



Informed trust

Stanton and Bevington (2005) also describe the need for 'informed trust' – a mutual reliance amongst board members based upon the presence of the three factors described above.

Informed trust gives board members assurance and confidence; it gives management permission and space to carry out their jobs, and leads to:

- a cohesive board
- full and open sharing of information and problems
- confidence among board members to express their views, doubts or lack of understanding of an issue
- the periodic and systematic review of 'old certainties', for example, 'patient safety always comes first'
- a healthy scepticism about receiving only good news – the trustee of an international charity noted that since the appointment of a new overseas director, the board had only ever heard of progress and achievement: 'Either we have found an exceptionally lucky new director, or we are only being told half of the picture. I think we have a duty to enquire'. An audit uncovered unreported difficulties which, if unaddressed, could have become critical

- creativity and innovation being balanced by appropriate scrutiny of potential risk
- ultimately, projects being delivered on time, to specification and to budget.

Building informed trust

Trust and challenge are mutually reinforcing: it is easier to challenge someone trusted, while challenge – scrutinising and probing – provides evidence for trust.

Achieving the right balance between trust and challenge requires conscious effort, and constant and critical review to avoid complacency. This demands courage, integrity, persistence and good intentions, and can be helped by:

- building trust first; it is easier for a trusting board to become more challenging than for a challenging board to start trusting. Trust can be built through:
 - getting to know one another informally
 - discussing attitudes to trust openly
- building a board with a diverse mix of backgrounds, gender, ethnicity and experience
- clarifying board members' roles
- appointing people who enjoy working in a team to the board.

Building bridges or building walls

As the earlier quote by Einstein implies, building bridges can allow enemies – as well as friends – to cross, while erecting walls may constrain and confine as well as protect. It is important for individuals and boards to distinguish between those deserving trust and those meriting caution.

Reflection

Is your tendency to:

- trust people until they are proved untrustworthy, or
- not to trust people until they earn your trust?

Does your tendency affect the board's decision-making and actions? Can you offer an example?

You may find it useful to discuss these questions with other board members.

2.5 INDIVIDUAL ROLE CLARITY

To function effectively, the board has to be clear about individual roles, and in particular the roles of:

- Chair and the Chief Executive (CE)
- Non-Executive Director (NED)
- Executive Director (ED).

The Healthy NHS Board expands on what each of these roles means (National Leadership Council, 2010). Ultimately, all board members, EDs and NEDs, have joint responsibility and shared liability for every decision made by the board, regardless of individual skills or status.

The roles of the Chair and Chief Executive (CE)

The Chair's main role is to ensure that the board discharges the three key tasks of gaining insight, clarifying priorities and expectation, and holding management to account (see Chapter 1). The Chair is not executive, so is not involved in the daily running of the organisation. In Foundation Trusts, the Chair is also responsible for leading the Council of Governors and ensuring that Governors understand their role and have the resources, information and knowledge necessary to discharge their duties.

The Chief Executive's role is to lead the Executive Team, ensure that the board's vision, strategy and priorities are achieved, and all risks are effectively managed.

NHS Chairs and CEs should respect the authority of the board as the ultimate decision-making body in the organisation. As Accounting Officer, the CE also has personal responsibility to Parliament for the overall performance and conduct of the organisation.

The Chair and CE share the role of communicating with key internal and external stakeholders, including regulators, but the CE should lead in communicating with external parties on operational performance issues. Chairs of Primary Care Trusts have a particular role in forming a strong relationship with Chairs of Professional Executive Committees.

It is critical that the Chair and CE agree their respective roles in writing and share this with the board. They should periodically reclarify their roles and seek feedback from board colleagues.

The role of the Non-Executive Director

'I am free to say what I want in meetings of the board since my mortgage and career progression do not depend upon my relationship with the Trust's Chief Executive or the SHA Chief Executive!'

An NHS NED

The key distinction between a Non-Executive Director and an Executive Director is the NED's independence. Their contribution to the board should be free from conflicts of interest. NEDs also have significantly less contact with the organisation than Executives, so can be more objective and see the broader picture.

NEDs' independence gives them an advantage in performing certain roles:

- • ensuring board-level challenge, especially when scrutinising management's performance
- • assessing the integrity of financial, clinical and other information
- • ensuring that financial and clinical quality controls and systems of risk management are robust
- • determining appropriate levels of remuneration for executive directors
- • having a prime role in appointing, and where necessary, removing executive directors, and in succession planning.

NEDs can use their experience and expertise to advise NHS managers, but should be mindful of pitfalls (see Reflection).

Reflection

'Throughout my career, I have appreciated the advice given to me by NEDs. But it is only advice. Individual NEDs who repeatedly tell me what to do and how to do it have crossed the line into management. If they insist I do what they want, what happens when it all goes wrong? Who should they sack – me or themselves?!

Of course I respect the authority of the board. The key difference is that the board makes its decisions as a group whereas a NED is acting on their own when they try to tell me what to do.'

If you are an ED, have you experienced the situation described above? If so, how did you deal with it?

If you are a NED, do you have a tendency to insist that your Executive colleagues act on your advice?

'I have had to give our EDs explicit permission to challenge NEDs. Since I've done this, they are contributing much more fully in board meetings.'

Chair, London-based NHS Trust

The role of the Executive Director

The ED has two roles on a unitary board:

1. in the governance role shared with NEDs
2. as head of a specific function (e.g. human resources or finance), providing advice and guidance on that function to the board, and answerable to the board through the CE for that function's performance.

EDs can use their experience within the organisation and with external stakeholders to help the board gain insight and clarify priorities and expectations. However, several barriers can hinder EDs contributing effectively at board level, in that:

- EDs do not like to challenge their board colleagues since it sits uncomfortably with being a team player. An Ambulance Trust ED said, *'I work with my Executive colleagues day in and day out and depend on them to deliver aspects of my portfolio. I want to support them and feel part of a team. Challenge just doesn't come into it really'*
- it may feel staged and pointless to challenge a paper they have already seen several times in meetings and committees
- EDs can be siloed by their area of expertise, e.g. the Medical Director may speak on clinical matters but not fully comprehend board-level financial discussions.

Reflection

As an Executive Director reflect on the following questions:

To what extent do you challenge your executive colleagues in board meetings?

How do you ensure that your NEDs have oversight of the challenge that a paper has already received in various other meetings?

Do you challenge outside of your area of expertise?

2.6 EFFECTIVE CHAIR/CE RELATIONSHIPS

The conduct of Chairs and Chief Executives (CE) has a significant impact on the board's effectiveness and the culture of the organisation.

Maintaining a healthy Chair/CE relationship

Amongst our interviewees and contributors to the NHS Institute research paper, there was consensus that the important components in a good Chair/CE relationship are:

- honesty
- communication
- trust
- clear roles.

These components are described in further detail in Table 2.2.

Chairs should:	Chief Executives should:
<ul style="list-style-type: none"> • be a source of support, practical advice and wisdom for the CE • be honest, direct and transparent • consult the CE before making decisions and keep them informed of conversations with key internal and external stakeholders • give the CE constructive feedback about the CE and other senior managers • be prepared to tackle inappropriate behaviour • adopt a businesslike approach. 	<ul style="list-style-type: none"> • be open and clear with the board; 'no surprises' • be willing to ask the Chair for advice or support • share ideas openly; promote discussion and analysis • try to understand the Chair and set out working relationships early on • drive the organisation forward • involve the Chair in strategic decision-making processes where possible.

Table 2.2 Components of a healthy Chair/CE relationship

Why Chair/CE relationships break down

Certain behaviours by Chairs and CEs can lead to a breakdown in their relationship. For Chairs, these include:

- trying to do an executive job
- getting too involved, leading to time wasting and misreading situations
- being too 'high maintenance' or needing to be 'entertained'

- challenging in a negative rather than robust way
- not supporting the CE when necessary; even bullying the CE or using NEDs to attack the CE
- over-reliance on the CE
- a macho, 'hire and fire' culture.

For CEs, these behaviours include:

- an autocratic style
- lack of communication with the board and Chair; constantly being 'in a hurry', leading to 'surprises'
- failing to value the Chair's contribution
- guardedness/secretiveness leaving the Chair feeling frustrated
- always analysing, debating and challenging, rather than 'doing'
- becoming too friendly.

The dangers of an autocratic style were highlighted in a study that found that boards with influential NEDs and senior clinicians are likely to have high 'use of resources' scores, while those dominated by CEs are disproportionately likely to perform poorly (National Institute for Health Research, 2010).

Reflection

As a Chair or CE, review the suggested list of behaviours that can lead to a relationship breakdown:

- Do any of them apply to you?
- If so, what action will you take?

2.7 CAPABLE BOARD MEMBERS

Capable members board are a prerequisite for board effectiveness. Our literature review and interviews with experts highlighted three aspects in particular:

1. the importance of NEDs understanding both their organisation and the business it operates in (as shown by business failures following the credit crunch)
2. the critical importance of diversity (of background, gender, ethnicity and age) to create diversity of thinking on the board
3. the importance of board succession planning in nurturing future talent (see case study).

The capability of board members can be assessed by looking at two aspects:

1. the board member's visible contributions to the board
2. the underpinning capabilities needed to make these contributions.

Contribution to the board

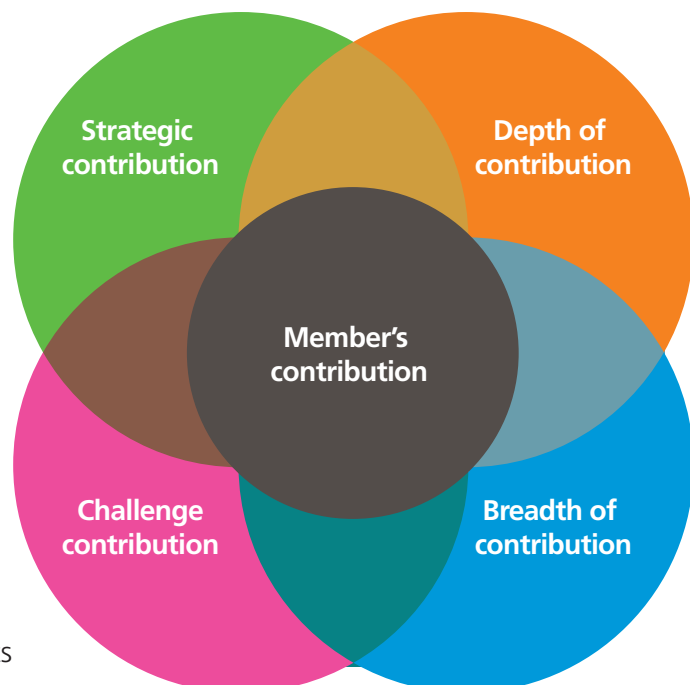
A board member's contribution to the board can be assessed by their:

depth of contribution – they are respected by board colleagues and people outside the board for their expertise in a given area (e.g. marketing) and routinely uses this expertise at board meetings and in discussions with individual board members

breadth of contribution – they routinely contribute to discussions outside their area of expertise, demonstrating a breadth of understanding of the organisation and its environment

strategic contribution – they are always forward looking in their contribution and appreciate the future opportunities and threats facing the organisation

challenge contribution – they can judge well when to challenge other board colleagues constructively on matters of material relevance to the organisation and its stakeholders.



Underpinning capabilities

In order to contribute in the ways described above, board members need the following underpinning capabilities:

- insight into the organisation – e.g. a clear knowledge of the services provided by the organisation and a high-level understanding of its capacity, capability and culture
- awareness of the organisation's environment – e.g. how the organisation as a whole and the services it provides are perceived by the local community and media
- clarity of role – e.g. a clear understanding of the role of the board and their own role on it
- personal values and motivation – e.g. consistently acting in the interests of patients and carers
- personal style – e.g. an ability to explain things without using jargon
- personal development and learning – e.g. willingness to admit and take responsibility for own mistakes and shortcomings.

Case study

Talent management and succession planning are crucial in major central government departments. Wanting to capitalise on the wider intellectual talent in the organisation, one department appointed high-potential individuals to a board to shadow the main board. This Shadow Board (SB) shadowed seven Management Board (MB) meetings during the course of the year.

How it worked:

Five days prior to MB meeting: MB Secretariat provided the SB members with the agenda and papers for the forthcoming MB meeting (with some exceptions relating to senior staffing).

Two days prior to MB meeting: the SB met. Two MB members attended each SB meeting, and the SB invited the authors of substantive papers to attend. A member of the MB Secretariat also attended as an observer to advise on board processes and procedures. The SB determined its own chairing arrangements and nominated two members to represent it at the actual MB meeting. The SB discussed and reached a considered view on each agenda item. A clear and concise summary (no longer than two sides of A4 paper) of the SB's conclusions was presented to the MB Secretariat.

At the actual MB Meeting: The two SB representatives were invited by the Chair to inform the MB deliberations of the SB's conclusions. These representatives also reported back the outcomes of the meeting to the rest of the Shadow Board. SB members received copies of MB minutes when circulated.

The following final case study draws together many of the issues raised in this chapter.

A global hi-tech company based in the United States, with an entrepreneurial founder, grew rapidly from zero into a public company worth several billion dollars. Various external and internal pressures led to a change of leadership and several board members. The role of Chairman and CEO was split, and the board and management team were experiencing considerable friction. An exercise was undertaken to:

- improve the quality of the relationship between the board and the CEO/senior management team (SMT)
- build a shared understanding of what was needed to sustain effective working relationships between all parties.

It was believed that the role and structure of the board should directly reflect its relationship to the executive management team (EMT), so the exercise focused on better understanding of:

- the strategic context of the business (e.g. industry and competitive challenges)
- key events and behaviours between the board and the CEO, and the board and SMT (e.g. levels of collaboration, management of conflicts)
- how to improve board effectiveness (e.g. meeting preparation and processes, board leadership, team dynamics)
- mutual expectations of board members, the Chairman, CEO and the EMT (e.g. regarding roles and responsibilities, board member involvement in discussions with management outside board meetings).

The board and the EMT were interviewed to identify issues and discuss potential recommendations for change. The outcomes concluded that:

- the structure of the board did not need to change

- the expectations of the board and EMT needed to be made clearer and more formal.

In addition:

- changes were made to the number of attendees from the EMT at board meetings, with only the CEO, CFO and legal counsel as regular members
- the Chair and CEO regularly met before each board meeting to strengthen communications between them.

It was also determined that:

- board meetings should be structured more formally
- the Chairman should take a stronger role in managing interactions.

The outcome of this exercise was that the Chairman and CEO were better able to collaborate on issues agreed as shared responsibilities, while focusing individual effort on the areas clarified as respective responsibilities.

This helped reduce tension in the EMT, who were also clearer about the expectations of the board. Board meetings became more efficient, as the Chair managed the dynamics of the meeting more tightly. The net effect was better working practices and more constructive dialogue between board and EMT.

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INTRODUCTION

The NHS in London faces significant challenges. Effective board leadership is essential, and boards and board members should:

- understand and adhere to their purpose
- be ever-attentive to critical areas of board effectiveness

This chapter considers:

- ten good practice principles for reviewing board effectiveness
- how board members can review their own contributions
- how to assess the board's impact.

We reviewed practice in the private and public sectors and found that good practice is already in place in parts of the NHS. Two case studies illustrating this are included.

3.1 TEN GOOD PRACTICE PRINCIPLES

Board effectiveness reviews should uncover any unknown unknowns – aspects of performance that only become known through deliberate, collective reflection or a fresh third-party perspective. An effective review process seeks to continually raise governance standards by:

- clarifying performance expectations for the board and its members for the coming year
- providing feedback to the Chair, Directors and board, acknowledging progress and identifying development areas
- supporting the re-appointment or removal of board members.

The Healthy NHS Board (National Leadership Council, 2010) gives guidance on NHS board performance review. Ten good practice principles that should underpin any review are explored below.

1. Clarify performance expectations

Performance expectations for the board and its members should be agreed at the start of the appraisal cycle. They should consider outcomes and capabilities and provide a benchmark for progress review.

'Reports that say that something hasn't happened are always interesting to me, because as we know, there are known knowns; there are things we know we know. We also know there are known unknowns; that is to say we know there are some things we do not know. But there are also unknown unknowns – the ones we don't know we don't know'

Donald Rumsfeld, Former US Defence Secretary

2. Both outcomes and capabilities are important

An effective board review should consider the:

- **outcomes** the individual or board should achieve
- **capabilities** they should demonstrate in achieving those outcomes.

Outcomes and capabilities should be consistent with individual or board roles (e.g. a NED should not be required to manage any aspect of the business) and fit organisational visions and values. Capabilities enable the boards and their members to be effective. The board's outcomes are to:

- meet its operational and strategic priorities
- operate in a way that meets its own expectations.

These might include:

- meeting yearly business plans, as a step towards delivering a five-year strategy
- changed regulatory requirements
- avoiding major incidents (e.g. NPSA 'never events')
- minimising risk
- effective engagement with stakeholders.

3. Review ED/NED contributions in the same way

ED/NED functional performance is routinely appraised, but their contribution to the board is often omitted. All directors, Executive or Non-Executive, have individual and shared accountability and should:

- share the outcomes agreed for the whole board
- be reviewed against the same standards
- have a Personal Development Plan relating to their board role and specifying their personal development goals.

There may be additional expectations of the Chair, due to their leadership role, and of members of particular sub-committees.

4. Use multiple review methods

Multiple methods should be used to assess achievement against expectations (see Table 3.1).

The most robust assessments use a combination of these methods, rather than relying on a simple approach.

Quantative: survey	Quantative: Personal interviews	Quantative: Group self-assessment
<p>Board members complete a written survey rating Board performance on a numeric scale; results are discussed by the full Board in a feedback session.</p> <ul style="list-style-type: none"> • Participants are familiar with this straightforward, standard practice. • Can be completed at a participant's convenience. • Can track a Board's progress over time. • Feedback sessions often focus on generating additional information and insights to supplement the survey data. • Anonymity can be assured 	<p>One-on-one interviews are conducted with each Board member; results are discussed by the full Board in a feedback session.</p> <ul style="list-style-type: none"> • Participants become involved in the interview process; most find it interesting an even enjoyable. • Information tends to be more detailed and complete than in surveys; helpful in fully understanding the issues and setting priorities, and developing plans to address them. • Feedback sessions tend to be highly engaging. • Anonymity can be assured 	<p>Trained facilitator leads a group discussion of the full Board; session summarised in a report for future use.</p> <ul style="list-style-type: none"> • Participants find the process energising and engaging. • Critical thinking is heightened because views are shared with everyone and participants can question each other. • Generates consensus on priorities and support for plans to address them. • Requires no preparation by participants. • Serves as a team-building exercise. • Most effective when there is a high degree of trust and openness among Board members

Table 3.1 Three approaches to Board evaluation

5. An external perspective

To provide an independent perspective, Corporate Governance Codes and the Walker review (Walker, 2009) recommend that external consultants facilitate board reviews at least once every three years.

6. Multiple perspectives

Include perspectives of patients, staff, commissioners, partners, Governors and other key stakeholders.

7. Process, not event

Review is a continuous process. Board members should provide informal, constructive feedback throughout the year.

8. Feedback skills

To give feedback you need:

- excellent feedback skills
- respect and independence
- commitment to the process
- to be honest about performance.

Only in the minority of review processes were Chairs/CEs open about individual performance.

9. Development

Board members need appropriate induction, training and development.

10. Review the review

The evaluation process should be periodically reviewed.

'I have filled in my highly confidential questionnaire and I was very honest about my views about everybody but unfortunately I left the questionnaire on the train.'

Royston cartoon of a board member confessing to board colleagues

3.2 REVIEWING CONTRIBUTIONS

Chapter 2 outlined a two-part framework for understanding and evaluating contributions to the board. The first part outlined four key contributions:

- **depth of contribution** – expertise in a given area (e.g. marketing)
- **breadth of contribution** – contribution to discussions outside area of expertise/function
- **strategic contribution** – forward-looking contributions
- **challenge contribution** – listening, probing and challenging.

The second part described underpinning capabilities NHS board members need to contribute effectively. Table 3.2 describes these in detail.

For EDs, the framework complements *Workforce for London's Next Generation Director and Chief Executive models* (NHS London, 2009), which focuses on the behaviours expected of senior leaders outside the Boardroom.

Board practitioners shared insights with us about working with and developing NHS board members. Areas of strength included:

- solid public service values and motivation to do a good job for patients and the public
- clarity about the board and board members' roles.

Areas requiring development included:

- EDs' reluctance to challenge in board meetings
- board members understanding of, and willingness to challenge on; clinical matters
- NEDs' understanding of the organisation.

Table 3.2 will help you to assess your own capabilities as a board member.

Table 3.2: Underpinning capabilities

Insight into the organisation: 'As a board member I...'

- can describe the board's vision and strategy for the organisation clearly and concisely
- can demonstrate how delivering the vision will improve the quality of care the organisation provides and/or commissions and the health of the local community
- can describe strategic initiatives to achieve the board's vision
- can explain the organisation's services and how it is structured
- can describe my organisation's high- and low-performing services from multiple perspectives, including quality of care and profitability perspectives
- understand the performance monitoring information presented at board meetings
- use my insight into the organisation's capability (skills and knowledge), capacity and culture to inform and improve the quality of board decision-making
- am mindful of how one part of the organisation's performance affects other parts of the organisation, especially in major care pathways or commissioning cycles
- can describe the key internal risks facing the organisation and how these are being minimised.
- can explain the financial position and performance

Awareness of the organisation's environment: 'As a board member I...'

- understand how the local community and media perceive the organisation as a whole and its key services
- understand current local and national health policy and likely future policy development
- have a deep understanding of the organisation's health and social-care market
- understand the regulatory and legal environment the organisation operates within
- appreciate national and local demographic trends and changes in disease profiles
- have insight into how my organisation's services perform relative to those of other similar organisations
- am mindful of how a number of national and international agendas will affect this organisation (e.g. the green agenda; an increased emphasis on corporate social responsibility).

Table 3.2: **Underpinning capabilities** *continued***Clarity of role: 'As a board member I...'**

- understand the role of the board
- can explain the differences between governing and managing
- can describe the board's governance structure, including the roles of board sub-committees
- can describe my own role on the board and my statutory duties as a board member.

Personal values and motivation: 'As a board member I...'

- consistently act in the interests of patients, their carers and the public
- have a strong commitment to the NHS and the NHS Constitution for England (Department of Health, 2010)
- am known internally and externally as a director that operates with integrity
- have never influenced a board decision for financial or other material benefits for myself, family, friends or others.
- help the board reach decisions objectively and impartially
- always declare any possible conflicts of interest.

Personal style: 'As a board member I...'

- am open and honest when communicating with the board
- welcome challenge of my reasoning, decisions and actions
- ask questions to comprehend discussions fully
- speak clearly and concisely and avoid jargon
- don't speak unnecessarily or dominate board meetings
- tailor what I'm saying to the needs of my audience
- always deliver on my commitments to the board
- maintain composure and effectiveness in the face of adversity, setbacks, opposition or unfairness
- have displayed courage in some of the board decisions I have contributed to making.

Personal development and learning: 'As a board member I...'

- have worked at senior levels in other organisations
- have worked in other sectors (e.g. wider public sector; private sector)
- am willing to admit and take responsibility for my mistakes and shortcomings
- invite and accept feedback on my own strengths and areas for development
- have a personal development plan in place to address my skills and knowledge gaps
- know my weaknesses and areas for development in order to fully discharge my duties and responsibilities.

3.3 EVALUATING IMPACT AND ENGAGEMENT

'A fish will be the last to discover water.'

Old Indian proverb

Board effectiveness reviews tend to be:

- introspective – interviewing board members about their own perceptions of the effectiveness of the board
- focused on areas that help the board do its job well – desktop-based reviews of the quality of board papers, minutes and agendas.

These activities are necessary, but not sufficient, to determine a board's effectiveness. Board members should not be the only ones commenting on their effectiveness. Reviewing agendas, papers and minutes alone does not show how effectively a board performs its three key tasks.

A board should seek the views of staff and other key stakeholders to:

- understand its true effectiveness
- better understand its impact on the organisation
- target areas for improvement
- demonstrate the value it adds
- improve engagement with the organisation.

Here, written from a staff perspective and arranged by key task, are examples of good practice statements against which boards can assess their own impact.

Gaining insight

- The board has a good understanding of the pressures on the organisation.
- The board listens to feedback from patients, carers and the public about their experiences of our services.
- There are effective channels for escalating issues for the board's attention.
- The board listens to the views and experiences of staff and could provide examples.
- The board is open to new ways of doing things from outside the organisation.

Clarifying priorities and expectations

- I understand the future direction of this organisation and my role within it.
- The board does not prevent me from doing my job effectively and efficiently.
- The board has clearly communicated what is expected of staff regarding quality and patient safety.

- I am aware of all the key risks (not just clinical) to the reputation of this organisation and know my responsibilities in minimising these risks.
- The board acknowledges staff who make outstanding contributions to patient care.

Holding to account

- Power and influence within this organisation rests with the board and not with any individual (e.g. Chief Executive) or professional group (e.g. clinicians).
- I would be happy for my own family to receive the care provided by this organisation.
- I would be happy to recommend this organisation to my family and friends as a good place to work.
- My manager behaves consistently with the values set by the board.
- The board resolves performance issues in a timely manner.

3.4 NHS CASE STUDIES

Two case studies highlight the critical importance of board development and review. It may be helpful to reflect on how your board might learn from them.

Case study 1

The Health Service Journal (Health Service Journal, 2009) described the regeneration of NHS Brent as an example of the critical role of first-class board leadership in transforming the NHS.

Before

An independent report on financial management and corporate governance at the PCT in early 2008 found evidence of an 'arrogant and isolated approach', 'serious failings of corporate governance', 'very poor financial oversight' and a 'schism' between the PCT and GPs.

After

The PCT is financially stable, doing well in the WCC assurance process and partners (GP's, Local Authority and providers) now feel respected. HSJ concluded, 'Although sorting out the money and governance is impressive, winning back trust so quickly is the outstanding feature of this success story'.

What made the difference?

Marcia Saunders, PCT Chair, attributed the transformation largely to:

- understanding what went wrong and systematically addressing the problems
- building the board from scratch and taking time to appoint the right people, including an excellent CE and experienced EDs and NEDs
- getting involved in London-wide activities and becoming more outward-facing
- accepting responsibility for what went wrong but not dwelling on the past
- redesigning governance structures to clarify accountabilities
- clarifying the Chair and CE roles
- active support and constructive challenge from community and clinical leaders, despite disappointment at financial and governance failures
- basing board relationships on trust.

Our research for this guide revealed how an NHS Mental Health Trust board transformed its effectiveness in under 12 months.

Before

The board was characterised by:

- unconstructive challenge from NEDs, described by Executive Directors as ‘never-ending’, ‘interrogation’, probing into too much detail’, ‘not focused on the right areas’
- the Chair’s autocratic and dominant leadership style
- excessively long board meetings (around nine hours)
- ‘them and us’ and ‘board within a board’ feelings of EDs reporting to NEDs
- staff fearing reporting ‘bad news’ to the board
- major commercial and development opportunities missed or put at risk by the board’s protracted decision-making.

After

The transformation reported by an independent review was evidenced by:

- a significant improvement in board relations
- a more collaborative and collegial board environment
- EDs feeling more supported by the NEDs (e.g. ‘I don’t dread going to board meetings any more’; ‘I don’t have to worry about what I’m going to say now’)

- more constructive and appropriately focused challenge
- EDs contributing more effectively as corporate directors (one NED remarked, 'EDs are much more engaged in board discussions and are talking outside their portfolio')
- board more clearly focused on a common set of organisational priorities.

However, board meetings are still around six hours long.

What made the difference?

Board members put the positive changes down to:

- an independent board effectiveness review
- committing to a board development programme
- the resignation of two NEDs
- a NED selection process explicitly testing ability to work in a team and challenge constructively
- the Chair's strong drive to improve effectiveness, including reflecting upon and changing leadership style through executive coaching
- development of a written board etiquette document explicitly describing behaviours expected of board members; statements clarifying the roles of the Chair, CE, board and executive team
- introduction of a board performance appraisal system based on good practice, monitoring effectiveness of the board and of individual members.

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INTRODUCTION

'The best boards send signals that safety is more important than productivity; [they] make patients and families full members of the care team; and most importantly, when tested will be steadfast in their support of quality and safety.'

Ontario Hospital Association

All patients and service users in the NHS have the right to receive high-quality and safe care. They also need to feel assured that the leaders and clinicians involved in their care are committed to maintaining and improving the quality of service provided.

NHS boards have a crucial role to play in ensuring that quality lies at the heart of all the Trust's activities.

This chapter focuses on the governance of quality and the board's role in ensuring high quality in three key areas:

- safety
- better patient experience
- health outcomes/effectiveness of care.
- This chapter looks in particular at the following three tasks facing every NHS board:
 - gaining insight into quality
 - setting priorities and expectations regarding quality
 - asking questions about quality.



4.1 GAINING INSIGHT INTO QUALITY

A key task of any board is gaining insight into the quality of services or products provided by the organisation. That insight is often based on information from external bodies:

- most notably, the Care Quality Commission's annual ratings, together with information from their inpatient, outpatient, emergency department and staff surveys (benchmarked nationally)
- Dr Foster Intelligence, like the Hospital Standardised Mortality Ratio and Patient Experience Tracker
- National Patient Safety Agency, including findings from the Patient Environment Action Teams and implementation of Patient Safety Alerts

Ways of gaining insight

However, NHS boards should not rely on information from external sources alone. Table 4.1 describes activities that can give NHS board members further insight into care quality.

Initiative	Description	Impact on quality and safety
Quality walk-rounds	Protected time for boards and senior managers to visit patient areas to talk to patients and staff about their experiences (see case study below: First Friday)	Makes leadership visible; feeds information straight into the board; offers valuable insight
Patient Representatives in committees and other meetings	Should certainly be considered for quality and patient-experience committees	Amazingly positive impact on staff; encourages staff to use less jargon; directly relates business back to patient experience
Begin every Board meeting with a patient story	Follow a recent patient story with discussion points directly related to issues of quality, e.g. surgical site infection, privacy and dignity, cancellations (see case study)	Highlights the impact of poor quality; focuses board members on the primary role of the board
Invite questions from patients in board meetings	Invite questions (not statements) from patients and the public at the start of board meetings; ensure questions are answered	Aligns patient experience to the core business of the board; helps prevent 'target myopia'

Table 4.1 Ways of gaining insight into quality of care

Describing quality

Board members with sufficient insight into their organisation's quality of care should be able to describe:

- which of the organisation's clinical services are excellent, and why
- which clinical services are performing poorly in terms of quality, and what management are doing about it
- the top three risks to clinical quality and patient safety, and what management are doing to mitigate them, including analysis of internal and external, current and future risks to quality

- how the Trust performs compared to other Trusts of similar size using measures of clinical quality and patient safety
- the organisation's performance in the National In-Patient, National Out-Patient and National Emergency Department surveys, and how these results compare with other similar-sized Trusts
- what staff satisfaction information says about the organisation's leadership and culture
- what the consolidated learning from Serious Untoward Incidents (SUIs), legal claims and complaints says about the organisation's quality of care.

Case study

First Friday, part of the quality drive at University Hospital of South Manchester NHS Foundation Trust, provides protected time (around one hour on the first Friday of every month) for senior managers and organisation leaders to visit patients and staff in frontline areas. *First Friday* aims to reduce barriers, make NHS leaders visible to their staff and patients, and give them a first-hand, structured understanding of front-line challenges.

A detailed resource pack provides guidance on:

- involving ward staff and clinicians in the visit
- respecting ward protocols
- complying with infection control protocols
- respecting the privacy and dignity of patients
- areas for discussion, including prompts (usually around quality)
- recording feedback or requests for fast action.

The Patient Liaison Team use 'knowledge capturing' templates to work *with* the senior managers to resolve issues arising from the visits. The feedback is then aggregated with other patient-experience data (claims/complaints/comments/compliments), enabling managers to form a holistic picture of good practice across the organisation and to identify areas for improvement.

With over 700 First Friday visits in the first year, the positive impact of the visits is clear from the enthusiasm brought back to the boardroom.

Reflection

'If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics and benchmarks and action plans that really matter, and that is what must never be forgotten when policies are being made and implemented.'

Robert Francis QC, Mid-Staffs Inquiry report, 2010

'Statistics tell us the system's experience of the individual, whereas stories tell us the individual's experience of the system'

Tony Sumner (2009)

Gaining full insight into quality requires full awareness and access to relevant information created from up-to-date and valid data, but equally requires that boards take advantage of the deeper insight that a range of patient experience information can give them.

Watch the digital stories below, and, as a board, discuss the possible implications for the board's need for insight into such issues as safety, record-keeping, equality of service provision, disability discrimination, litigation and corporate liability. How does the board know that similar problems are not arising in the organisation.

A fighter from the start – www.patientvoices.org.uk/flv/0141pv384.htm

Jimmy's story – www.patientvoices.org.uk/flv/0047pv384.htm

'When times are tough and money is tight, and some are tempted to concentrate solely on hitting targets or just cutting costs, that's when a non-exec chairman should quietly step in to remind everyone that the customer still has the same expectations and that the original vision to deliver excellence is still within grasp.'

Chairman, Acute Foundation Trust

4.2 QUALITY PRIORITIES

Once a board has gained insight into the quality of its healthcare, it will need to decide what the organisation's priorities should be.

Deciding what to prioritise

Priorities for high-quality healthcare are largely defined by the Care Quality Commission, and for PCTs have been World Class Commissioning Assurance and locally agreed targets (including Commissioning for Quality and Innovation payments). The advent of Quality Accounts (see below) will, however, give NHS boards the freedom to prioritise certain quality improvements over others. Their decisions will need to be based upon:

- sufficient insight into which aspects of care are good and not so good
- an appreciation of which aspects of care stakeholders would like to see prioritised (and evidence-based practice suggests are worth prioritising).

The most important tests of quality accounts will be that:

- they make sense to the public
- they enhance accountability.

NHS boards can only be certain of improving care quality where they can measure it and so should prioritise quality goals that can easily be monitored. The Information Centre for Health and Social Care has developed a series of Indicators for Quality Improvement that cover each of the three domains of quality (see Introduction). These indicators are:

- assured by clinicians
- capable of being used to benchmark the performance of one Trust against another
- published with full metadata to promote transparency.

Accounting for quality

Setting indicators and quality goals is complex for boards, so it is advisable to establish a project group that has a direct line-of-sight to the board.

Quality Accounts

Providers of NHS services are now required to publish Quality Accounts – reports for the public on the quality of the services they provide. Providers are required to identify their priorities for improvement and the indicators they will use to measure their performance. There are over 200 unique metrics, which cover clinical measures, patient feedback and progress against implementing standards, policies and tools. On average, in 2009-10, foundation trusts identified five different metrics on which they would focus, with Healthcare Acquired Infections (HCAI) and Hospital Standardised Mortality Ratios (HSMR) the most commonly chosen.

Quality Accounts aim to:

- increase NHS accountability by making more information about quality available to the public
- encourage boards to focus more on quality improvement.

To construct Quality Accounts there should be:

- evidence of clear dialogue in your organisation between clinicians, providers, patients and staff to determine the basis for quality

- a clear outline of quality domains
- a clear statement of intent that gives a general indication of where the board wants Quality Accounts to go – how you will turn the vision into reality
- some statutory information and indicators set by, for instance, Monitor, the Department of Health and the CQC, but overwhelmingly, information local to your organisation and objectives.

Information on Quality Accounts is available at www.foundationtrustnetwork.org and www.kingsfund.org.uk. For examples see www.monitor-nhsft.gov.uk.

In deciding which aspects of quality to prioritise, an NHS board should have:

- sufficient insight into the quality of care provided and/or commissioned by the organisation
- specified a number of specific quality goals/improvements
- fully engaged staff and stakeholders in a dialogue that is fair and open to scrutiny
- ensured that quality and safety are the basis for their vision and strategic priorities
- ensured that the organisation's quality goals are aligned with the priorities of commissioners, patients, the public and government.

4.3 QUALITY EXPECTATIONS

The board should clarify its expectations about how management and clinicians should deliver the priorities it sets. It should expect senior management to promote, nurture and protect a 'quality culture', in which healthcare professionals routinely ask themselves:

- *'Am I doing it right?'*
- *'How can I do it better?'*

Promoting a culture of quality

Table 4.2 describes some initiatives that can be used to promote a quality culture throughout the organisation. These initiatives should be read alongside the ones described earlier in Table 4.1.

Initiative	Description	Impact on quality and safety
Promote quality through communications	Message of the day' – brief description of a recent patient safety incident, or initiative such as infection control; screen savers are a powerful tool	Keeps issues of quality and safety in the minds of all staff all day
Reduce silo working	Consider 'work experience' across the organisation, e.g. a nurse working a day in the complaints or coding department	Helps encourage 'one team'; seeing consequences sharpens up practice
'One good idea'	Regularly ask each member of staff for one good idea to improve the quality of patient experience (each division puts forward its ten best ideas); quality ideas are found in unexpected places	Empower staff to be experts in their own areas of work and harness this knowledge
Set clear targets	Set realistic but challenging goals, avoiding generalisation: not 'we will reduce MRSA rates by 50% by the next quarter' but 'we will have no more than two cases of MRSA in three months'	All staff can work towards clear and identified goals
Set expectations	Ask management to present evidence of the efficacy of a recent quality improvement programme in their relevant area of business at a board meeting	Encourages and rewards staff for being attentive to quality
Celebrate and promote individuals and teams	Staff awards, annual ceremonies and promotions are good ways to promote a quality culture	Staff can clearly see that if they personally invest in providing a quality service, they will be recognised.

Table 4.2 Quality culture initiatives

When expectations aren't met

But what happens when individual clinicians and teams consistently underperform in relation to the board's quality priorities and expectations or ignore the board's expectations altogether? There are no easy answers. Consider the following two extracts from an Acute Trust board, and as a board answer the questions that follow it.

Case study

From an NHS Acute Trust board report, July 2009

An incident of wrong site surgery has been reported to the PCT and SHA. The incident occurred in May 2009 and has also been reported to the NPSA since wrong site surgery is also classified as a 'never event'. A committee has been established to oversee the implementation of the WHO Safer Surgery checklist (NPSA alert 2009). This checklist, once implemented, aims to increase the safety of patients undergoing operative procedures by ensuring a robust checking process in theatres. The checklist is currently being piloted in orthopaedic theatres and full implementation of the checklist will be achieved by 1st December 2009.

From board report January 2010

Between July and December a further incident has been reported to the PCT and SHA. This occurred in September, where a patient underwent an incorrect procedure in day-case orthopaedic theatres. The incorrect procedure was recognised and the correct procedure was then undertaken. The investigation process is underway, however preliminary findings include:

The same surgeon was involved in the previous never event in May 2009; he is frequently uncooperative with management teams around the implementation of new ways of working.

The WHO safer surgery checklist was not completed correctly.

Reflection

What questions would you ask, given two related 'never events'?

What actions would provide evidence to assure the board that the events would not happen again with the same clinician and other clinicians?

What level and quality of information should the board receive on Serious Untoward Incidents?

How would you check the commitment of clinicians to implement local and national guidance?

How would you challenge the behaviour of an uncooperative clinician on such an important aspect of quality and safety? What signals would you want to send to the rest of the organisation?

(Case study used with the permission of NHS Yorkshire and the Humber.)

4.4 ORGANISING THE BOARD

NHS boards need to decide the most appropriate behaviours, structures and processes to govern quality. Much can be learned from cases where NHS boards have failed patients and the public, as in the case of Maidstone and Tunbridge Wells NHS Trust (see below and also the Mid Staffordshire NHS Foundation Trust case study in Chapter 2).

Learning from failure

These cases highlight the importance of having:

- the right dynamic in the boardroom – not dominated by one voice or one group
- challenge appropriately balanced with trust
- a relatively stable board with an ‘organisational memory’
- a relentless focus on quality (at least 25 per cent of the board’s agenda)
- clear roles and accountabilities in relation to quality
- sufficient clinical challenge on the board
- a healthy scepticism about reliability of information presented to the board – *‘How do we know what we know’; ‘What are the data sources for the information I am being given?’*
- systems and processes that triangulate information, for instance:
 - does the information from formal board reports corroborate information from other sources?
 - does the board triangulate claims, complaints and incident information intelligently and discuss the content not just the numbers at board level?
- a board that stays on top of issues until they are resolved
- an appropriate induction for new board members.

Now read the case study below and consider what you or your colleagues on the board can learn from the findings.

In 2005, the Maidstone and Tunbridge Wells NHS Trust, an 800+ bed Acute Trust, suffered an outbreak of Clostridium Difficile (150 cases), unrecognised at the time. Some seven months later, in April 2006, a second, larger outbreak (258 cases) was reported to the SHA and the Health Protection Agency. The main findings from an independent report into board leadership at the Trust published in May 2008 are reported below.

Leadership

The Chief Executive, who was initially appointed to the role to resolve some ongoing difficulties associated with nursing and quality of care, had an inflexible, and sometimes inappropriate style of management. This leadership style prompted a gradual 'retreat from challenge' by senior executives and also a steady migration of senior post holders. The CE, in recruiting new posts, missed the opportunity to employ experienced executives (at least two members of the board were on their first executive appointment). The CE did not cultivate a strong board.

The trust did have a highly capable Chair, who in turn appointed some potentially very dedicated and skilful non-executive directors. However, they were not sufficiently inducted into the organisation and were not provided with enough training or support. The relative newness of the board combined with unclear objectives and reluctance to challenge meant that the board had a stepped-back approach to governance and a lack of control, insight and assurance. There were woefully tenuous links to the 'memory' (long-standing quality concerns) of the organisation and a failure to progress towards objectives. The combination of a dysfunctional board, an ineffective governance system and the failure to address a fragmented culture resulted in the catastrophic and unnecessary loss of life.

Board agenda and reporting

There was an increasingly large amount of paperwork associated with each agenda item at board meetings which had in turn, become slightly generalised and 'tick-box'. This failure to distil information appropriately made it hard for the board (particularly for NEDs) to establish what to infer and what to challenge (for example, increasing mortality rates). The board front-sheets often asked the board to 'note' rather than 'discuss and agree' or 'ratify' information. Board minutes show that the predominant issue was the desire to become a Foundation Trust, performance and finance. There was little or no discussion of quality

and safety, which ensured these crucial items slipped further down the board's agenda.

Non-clinical board members felt unable to challenge clinical issues that were raised 'for the board to note'. Discussion of complaints and patient experience issues were largely absent from board agendas, as were discussions of incidents, SUIs or any remedial actions. Had patient experiences been prioritised by the board, presented in an intelligent format and subsequently challenged, there would have been ample opportunity for patients' concerns to raise the appropriate alerts. In this particular regard, there are resounding similarities with Mid-Staffs.

4.5 HOLDING TO ACCOUNT IN RELATION TO QUALITY

Constructive challenge is the primary means by which a board seeks assurance from management that its priorities and expectations are being met. Below are some useful areas to probe and questions for the board to ask itself and management in relation to the provision of high-quality, safe care.

Promoting a culture of quality – questions for the board

- Do we fully understand the quality problem being reported to us?
- Has this issue happened before? If so, why is there a recurrence?
- Do we have the right capabilities to hold the executive to account in relation to clinical quality and patient safety?
- Are we assured that the arrangements we currently have in place to deliver our quality goals are sufficiently robust?
- How do we know that our quality goals are having the positive impact on quality care that we intended?
- How do we typically respond when decisions are not implemented or deadlines slip?
- How do we respond to staff that persistently violate our patient safety policies?
- How do we know that the consolidated learning from SUIs, claims and complaints has been shared across the organisation? How do we know that the improved practices resulting from this learning have been sustained?

- Is the information provided in board meetings consistent with the feedback from governors (if an FT), patients, staff, the public and through the media?
- Is our incident reporting rate with the National Reporting and Learning Service higher or lower than other similar sized Acute Trusts, and do we know why?
- What assurance have we received that staff understand how to identify, report, control and, if necessary, escalate clinical risks within the Trust?
- Is clinical risk management standardised across the Trust?
- Could we give two examples of changes that we have made as a result of feedback from patients/carers?
- Are we happy with how we are kept up-to-date with the work of the Clinical Governance/Assurance Committee?
- What assurances have we received that management capability and capacity below the board, in particular amongst the Clinical Directors, is fit for the purpose of delivering high-quality, safe patient care?
- How do we know that all staff understand the clinical quality standards expected of them? Do the board's quality goals link with those of divisions/directorates?

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INTRODUCTION

'Boards need good powers of analysis, good sense of reality, and awareness of and openness to what's going on in the outside world.'

(NED, acute trust, London)

NHS board members give their time and energy because they want to make a difference. Effective strategies help deliver this difference by linking their vision to the actions and initiatives of the organisation.

This chapter will cover:

- the board's role in formulating strategy
- the skills and knowledge required to operate as a more strategic board
- the board's role in undertaking effective strategic planning
- the characteristics of a strategic board meeting
- how the board holds the Executive to account for implementing strategies.

5.1 GAINING INSIGHT AND STRATEGY

NHS boards face difficult decisions in London's changing environment of cost pressures, government regulation, and increasing patient diversity and demands. The uncertain environment requires sharper strategic thinking if boards are to deliver current and future priorities, and boards should be involved in formulating strategic planning from the outset.

The NHS has many definitions of 'strategy' and 'strategic plans'; boards need to clarify with their executive team and management what is actually 'strategic' and so merits the board's attention.

What follows is a good practice process for developing a strategic plan – 'a broadly-defined plan aimed at creating a desired future' (www.businessdictionary.com).

Once developed, the strategic plan should not be viewed as a static document. Since the future is unpredictable, it is essential to build flexibility into strategy development. The board also has a central role in ensuring flexibility is not mistaken for a lack of direction or purpose.

When developing strategy, the board should focus on identifying assumptions based on uncertainties about how external events may develop, such as other

'In developing strategy, boards must recognise potential futures. People in the public sector tend to think of one future - that's not the case, there are many different futures and scenarios that need to be considered and planned for'.

(NED, acute trust, London)

'There is a tendency for Execs to 'tinker' with strategy, rather than really look at the fact the world is changing, what do we need to do differently in five years time; how will we get there?'

(NED, acute trust, London)

providers' actions or the outcomes of PCT provider separation. The board should ensure that:

- options are identified for different eventualities
- the strategy adopts the most appropriate course of action
- strategic planning uses the best information currently available.

Five steps for formulating strategic direction

The board's role in formulating strategic direction has five steps:

1. Gaining understanding and insight into the market, the broader external environment and your organisation's internal capabilities by:
 - assessing the full range of local, national and international trends – demographic, economic, social and health-related – that will impact the organisation over the next 10+ years
 - defining the organisation's strengths, weaknesses, opportunities and threats (SWOT)
 - reviewing likely and possible structural changes in the market such as new entrants, mergers and service reconfigurations
2. Early and regular engagement with a range of stakeholders:
 - all stakeholders should be involved in formulating strategy at the outset, rather than feeling they are being 'sold' the organisation's ideas
3. Determining the plausible strategic options available:
 - based on insight gained and stakeholders' views
 - articulating effects on patients, staff and other key stakeholders
4. Identifying uncertainties and potential challenges:
 - by considering how changes in assumptions underpinning strategy may affect plans
5. Determining the measures of success for the strategy by:
 - considering using quantitatively measurable criteria to measure achievement of strategic options that may have been described in qualitative terms.

The prescriptive nature of the World Class Commissioning assurance process can lead PCTs to focus planning on simply meeting estimated future needs rather than creating a desired future. Recognising this issue, one PCT recently embarked on a six-month strategic development exercise with the objective of defining its future state and how it planned to achieve it.

They consulted a wide set of stakeholders (including the local population, GPs, consultants, nurses, the local authority, public and private sector providers) by holding town hall meetings, running workshops, conducting surveys, involving the local media, carrying out one-on-one interviews and using other techniques.

From this work, the PCT formed a desired future of a healthier population supported by a financially sustainable local health economy, with low prevalence of key diseases and effective, cost-efficient care close to the patient's home. The high level of local engagement allowed them to identify creative ways of delivering this vision, but also ensured maximum support – and enthusiasm – for their plans.

A clear picture emerged of a future that included:

- the elimination of expensive avoidable hospital admissions, freeing up acute capacity for those in greatest need
- GPs empowered to explore options other than acute clinicians for obtaining professional advice and support needed to care for patients
- more effective contract management and reduced unit cost of services delivered by providers
- a financially sustainable network of service provision across the locality
- high patient satisfaction and fewer people experiencing health inequalities
- best value for money for every pound spent.

By identifying possible obstacles to the strategy, the PCT developed a small number of high-priority initiatives aimed at cutting costs and delivering this desired future within the five-year timescale of the plan:

- Devolve commissioning budgets to clusters of GP practices, giving them responsibility for commissioning health services for their patients.
- Temporarily suspend elements of Payment by Results, and re-balance risk and incentives between commissioners and providers.

- Invest only in acute services that are clinically effective.
- Look at new ways of enabling GPs to obtain swift advice in making the decision to refer a patient to hospital.
- Support the development of community services as a viable alternative to acute hospital care.
- Radically transform services for three clinical pathways with the greatest impact in managing long-term conditions.
- Focus on preventative work, with a particular focus on smoking cessation.
- Streamline existing strategic initiatives and progress cost-efficiency programmes to provide the resources to invest in agreed priorities.

With a high level of direction and clarity, the plan has given the PCT and its stakeholders the confidence to take bold steps in implementing the strategy.

Taking strategy seriously

The NHS boards that have taken strategy development seriously and benefited from it include:

- an acute trust that cancelled a private finance initiative (PFI) because it didn't fit the trust's strategy
- an NHS trust able successfully – and rapidly – to respond to an opportunity to merge with another healthcare trust, because it was already clear to the board that this opportunity supported the organisation's strategy
- multiple trusts partnering with an academic institution to create an Academic Health Science Centre, combining the skill and expertise of clinicians and researchers.

'Do I understand and feel able to rely on the information that is being given to me?... Am I confident that the Executive Team have approached this issue with due process, and are making clear and well supported recommendations?'

Professor Bob Garrett, Chairman, academic and author on board development

5.2 HOLDING TO ACCOUNT AND STRATEGY

Once a course of action is chosen, the Executive Team should be mandated to make the necessary investments and deliver that strategy. The board's ongoing responsibility is to monitor any uncertainties and assumptions so that, as these become clearer, the decision can be made to change direction if necessary.

Challenging strategic plans

There are some key areas boards should question when reviewing and assessing a developing strategic plan.

Rationale

- Is the rationale for this strategy clear, consistent and logical?
- Is the plan understandable by all audiences?
- Is the proposed strategy clearly the best option?
- Are the reasons for rejecting alternatives clear?
- Does the plan fit with our vision?
- Does the plan fit with the external environment, especially the guiding policies and strategies of governing or peer organisations?
- Does the plan support the image the organisation wants to convey?
- How will the diversity of our public view the plan?
- Does the plan build on organisational strengths?
- Does the plan overcome or minimise organisational weaknesses?

Ambition and impact

- Is the plan over-ambitious?
- Does it meet the requirements of our regulators?
- Does it meet the needs of our patients and public?
- How will our plan enhance (or diminish) quality of care?
- How does this plan do enough to address issues of health inequality and stakeholder diversity?
- Is there evidence to support assumptions on degree of impact?
- Does our plan contain a realistic appraisal of the organisation's markets, customers and competition?
- Are we planning to do the right things in light of this assessment?

Achievability

- Do we have the capability to deliver our plan effectively and on time?
- Do we have the resources to deliver our plan effectively and on time?
- Is the timing of the plan realistic and achievable?
- Does the organisation have the leadership and workforce capacity and capability to sustain our plan over time?

- Have the strategic and operational risks been adequately assessed and understood?
- Does our plan appropriately balance risk and return?
- Are there clear plans for mitigating proposed risks, with clear responsibilities and plans for delivery (financial, strategic, operational, etc.)?
- Are the financial costs required to deliver our plan clear and do they support value for money?
- Is the organisation structure compatible with the objectives of our strategic plan?

Measurability

- Are there clear measures of success, appropriate to our strategic objectives?
- Do we have mechanisms to monitor and measure delivery and take remedial action on shortfalls?
- Are activities in the plan feasible to implement?
- Will activities in the plan deliver proposed benefits?

Strategic execution

The board has a critical role in holding the Executive to account by regularly scrutinising the implementation of strategic initiatives against milestones and objectives. The board's role is as follows:

- Management tracks progress towards implementation of the plan, providing explanations to the board for areas of non-delivery, suggesting remedial action or requesting board input where no remedial action can be found.
- The board receives management's update on delivery and provides direction where requested.
- The board identifies and monitors uncertainties, regularly re-evaluating strategy in light of changed internal and external environments.
- If an uncertainty becomes known, the board determines whether strategic direction needs to change.
- Management adapts the strategic plan as appropriate, and continues to deliver and track progress.

5.3 CHARACTERISTICS OF NHS BOARDS THAT GET STRATEGY RIGHT

When preparing this guide, research and interviews highlighted the following characteristics of NHS boards that are effective at strategy:

- providing active leadership in a way that gives confidence to the organisation and its stakeholders and shows that the board fully owns the strategy
- bringing to bear relevant experience, diversity and outside perspectives (either from NEDs or third parties) to influence strategic direction
- nurturing appetites for knowledge, so board members fully understand the organisation's context . This includes staying abreast of healthcare trends and using contacts to gather insight into what peers and competitors are doing
- thinking and planning far into the future, ten years and beyond. By removing themselves from day-to-day operations, board members can visualise future opportunities, constraints and opportunities
- using logical structured thinking to understand the factors driving strategy –assessing whether strategic options put forward will result in the desired future and identifying uncertainties that could affect the strategy
- constructively challenging the rationale behind strategic ideas – probing underlying assumptions and ensuring board insights are incorporated into strategic ideas
- exposure to, and understanding of, external strategic influences, such as DH policy – although often challenging for part-time NEDs, actively nurturing such awareness is a responsibility of all boards.

Many board members come from non-clinical backgrounds, but this should not stop them challenging or acting decisively on clinical strategic matters. As well as harnessing the expertise of those on the board with clinical expertise, board members can strive to stay up to date with clinical developments that might impact on the organisation's work and strategy.

'Boards have to have the ability to understand information, look at trends and what they mean, understand where they are compared to other organisations and understand and probe the reasons for high or low performance'

(PCT Chair)

Case study

Here are some board members' thoughts on strategy and the role of the board, revealed during our research for this guide.

'Core skills needed by the board are traditional strategic thinking and change management.'

(NED on an NHS board in London)

'There is a danger that Executives have a tick box mentality when it comes to strategy... the board has to work on changing the mindsets of senior executives.'

(NED, Acute Hospital, London)

'It is important to pick up trends and broad patterns – without this knowledge board members are at a disadvantage in discussions.'

(PCT Chair)

'Boards need skills of challenge; they have to keep probing the Executive Teams until they get a satisfactory answer, which can be uncomfortable for Executives. It's important to balance the need to challenge, whilst preserving a supportive relationship.'

(PCT Chair)

Reflection

Table 5.1 below lists positive and negative indicators of strategic visioning. Whilst intended for Chief Executives, most of them apply to any NHS board member.

To what extent can you apply the indicators to your role?

To what extent do you demonstrate the relevant positive indicators listed?

As a result of this reflection, what are your key areas for development?

Capability	Positive indicators	Negative indicators
Forward thinking / compelling vision	<p>Sets clear direction and articulates a compelling vision for change, in the context of the wider system</p> <p>Considers issues in a systemic manner, understands the broader organisational context</p> <p>Thinks through the future consequences of actions on all stakeholders</p> <p>Considers new/radical ideas and challenges current thinking</p> <p>Understands and considers the strategic intent of the wider NHS in London</p>	<p>Fails to set clear direction or create a compelling vision</p> <p>Thinks narrowly in terms of their own organisation Fails to think systemically</p> <p>Fails to consider the consequence or impact of their actions on others</p> <p>Creates pedestrian strategies of incremental change</p> <p>Does not identify how their strategy sits within the wider strategy of the NHS in London</p>
Understands effective commissioning conditions	<p>Understands and seeks to create the conditions for effective commissioning</p>	<p>Lacks in-depth understanding of the commissioning process</p>
Considers patient and public needs	<p>Places patient and public needs at the heart of their thinking</p> <p>Underpins their vision and action with a strong focus on local needs</p> <p>Demonstrates a strong commitment to improving service performance and health outcomes Takes proactive steps to improve service delivery through new ways of working</p>	<p>Fails to consider the needs of patients and the public in their strategic planning</p> <p>Lacks sufficient understanding of local needs to create an effective strategy</p> <p>Acts without an underpinning purpose to improve health outcomes</p>

Table 5.1 Leadership capability: Strategic visioning indicators

'[We]...need to understand strategy, look to the long term and keep focused ... we all have the temptation to go into too much detail'

(NHS board member)

5.4 STRATEGIC BOARD MEETINGS

Effective board meetings should have the organisation's strategic direction as their focus, yet board members often complain that meetings get bogged down in operational matters. Effectively conducted strategic board meetings:

- focus on the external environment, with enough time to discuss market developments, policy changes and other uncertainties that could impact on strategic direction
- are appraised on key elements of strategic delivery – by means of an update on whether key elements of strategic delivery are on track, as assessed against agreed criteria. Where delivery is not on track, the remedial action being taken should be set out. Where the size or nature of non-delivery means remedial action is unclear, the input of the board will be crucial
- have an agenda appropriately balanced between strategic and operational items – enabling the board to contribute their time and skills effectively to aiding strategic development
- are characterised by members challenging constructively – questioning the rationale of the organisation's strategic direction and discussing events that suggest a change in direction.

Reflection

Does the description of effective strategic board meetings above match your own experience?

If not, how would you seek to improve performance?

Which area would you address first?

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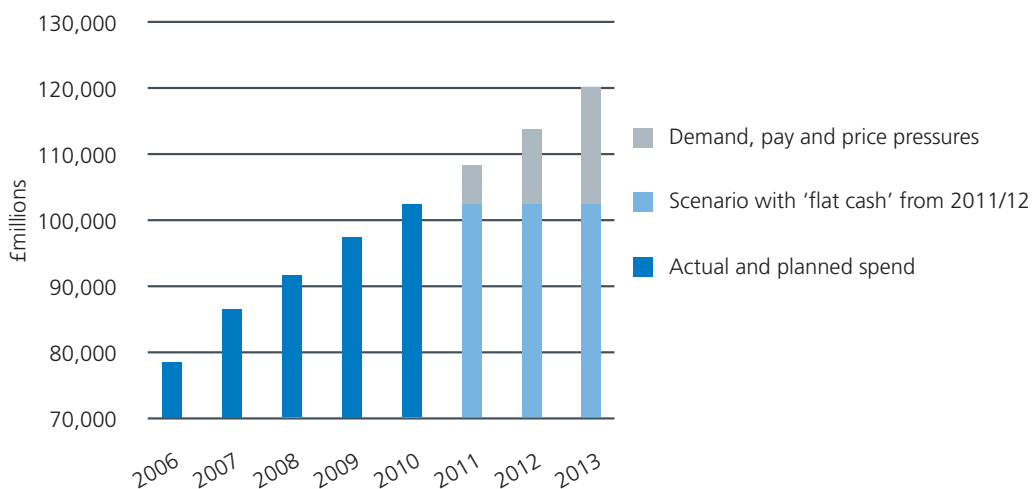
INTRODUCTION

The NHS faces potential funding gaps of £15–20 billion, with estimates for NHS London standing at £5 billion. Every NHS board is now operating in an environment of downturn, not growth.

'It would be a mistake to underestimate the challenge or the opportunity the downturn provides'

Niall Dickson, CE, The Kings Fund, July 2009

NHS expenditure by year



This chapter aims to:

- stimulate boardroom debate on responding to the financial downturn
- explore the nature and viability of cost-reduction schemes
- review the balance between clinical quality, and making productivity and efficiency savings
- look at an organisation's capability to measure productivity.

This chapter also looks how boards can gain insight into financial challenges it faces, set priorities for cost reduction plans, and hold management to account in delivering its priorities.

6.1 THE BOARD IN AN AGE OF AUSTERITY

All NHS board members:

- are accountable for the financial health of their organisation
- have a duty of care to the patients for the quality of the services they receive.

Particularly in times of financial stricture, a key task of any board is to hold

'All too often the ownership of cost reduction schemes resides with too few executive directors and NED involvement occurs too late.'

Senior cost reduction consultant

management to account and seek reasonable assurance they are delivering the board's organisational priorities and expectations.

Reflection

John Simons, Chair of Enfield Community Services, and Julia Brown, Chief Operating Officer, shared with us some key lessons learnt from operating in a financially challenged environment:

'Honesty and transparency are key – apply them to all your practices.

Meet frequently (weekly) with stakeholders to update them.

Do not neglect talent management in favour of interim positions.

Ensure clarity about who is doing what in the transition.

Get the composition of your board and quality of leadership fit for purpose - performance manage where required early.

Create a positive but realistic tone at the top – listen.'

What are you doing differently as a board to adapt to the new financial climate?

NHS board members bring a variety of experience, views and talents to their task of governance. This diversity can help the board take a much broader view of the issues it faces in financially stringent times, but to make best use of this diversity, boards should be inclusive and mutually supportive.

Typically, the finance director and NEDs with a financial background 'own' cost reduction. Whilst gaining assurance from colleagues' expertise, all board members, regardless of expertise, should gain insight into and debate key areas:

- the cost reduction plan – all major schemes; how they have been put together
- the plan's high-risk areas
- contingency arrangements and mitigating strategies
- actions to ensure quality is not compromised.

Reflection

As part of the Better Care healthcare programme, clinicians from the Epsom and St Helier Trust organised a workshop with PCT clinicians to discuss service improvements and financial implications; part of the workshop included agreeing a target percentage for reduction in hospital admissions.

How does your organisation ensure clinicians consider cost reduction?

Engaging others

To ensure the success of cost reduction plans, boards must ensure that all stakeholders are signed up to the measures. This means involving them closely in developing the plan. Ways of doing this include:

- focus groups with clinicians to debate the board's proposed strategy
- frequent 'walk arounds' with clinicians to gain insight into their experiences and views of actual or proposed cost saving plans
- inviting clinicians to board meetings (and sub-committees) to present their cost reduction ideas and to track progress.

'In my experience boards tend to work hard to engage stakeholders but ways of engaging stakeholders (specifically clinicians) in relation to cost reduction could often be improved.'

Associate Partner, professional services firm

Reflection

'You're telling me that there is an aging population, increasing demand for our services, medical technology is increasing at a rate of knots allowing us to keep people alive for longer... and you want to cut my services?'

A general practitioner

As a board, debate your response to this statement.

6.2 GAINING INSIGHT INTO COST REDUCTION

A board's first key task is gaining insight. Where board members, especially NEDs, lack insight into an organisation's financial position or mechanisms, the results can be disastrous, as shown by private sector's financial crisis during the credit crunch.

In 2001, when Enron collapsed, its board included a former Ivy League accounting professor, the previous CEO of an international bank, and an economist who was once the head of the US Government's commodity futures trading commission. Yet members of this board claim to have been confused by Enron's highly complex financial transactions – they lacked sufficient insight.

A past track record in cost reduction is a reasonably good predictor of future success, but many NHS board members lack sufficient insight into basic cost reduction areas.

'At the time I left the company, I fervently believed that Enron would continue to be successful in the future. I did not believe the company was in any imminent financial peril.'

Jeffrey Skilling, Former CEO, Enron

Reflection

Think about the following questions in the light of your board experience.

To what extent does your board have insight across your health economy?

Is this insight sufficient to support and evaluate the impact of pathway redesign?

Getting the right information

The quality of the financial information the board receives is vital. The Director of Finance is responsible for ensuring information is clear and can be debated. Other members are responsible for requesting the information required to transform services.

Historically, organisations focused on information generated internally. They will now need to use indicators from across the whole health economy to assess the quality and financial benefits of planned changes.

Reflection

Use the following questions to reflect on your own current level of insight.

What is the organisation's past cost reduction performance? Have you always met your targets?

- If yes, have they been met as originally planned or via non-recurrent measures?
- If no, why not?

What is your level of intended savings in percentage and absolute terms for the next financial year and for the medium term (5 years)?

For both these scenarios, how will the organisation achieve these savings?

Are these savings realistic? How do you know?

What is your fallback position if these savings are not realised?

Has the whole board considered all risks in determining the size of these plans and the associated mitigating strategies?

For providers – how does your level of required forecast savings compare to the PCT's commissioning intentions?

For commissioners – how does your level of demand management and efficiency savings compare to the provider's expectations of activity and revenue?

How are cost reduction schemes fit in with overall strategies for healthcare in London?

What expectations of cost reductions do key external parties have of your organisation?

How have you engaged staff, especially clinicians, in the development of cost reduction plans? Where would clinicians suggest reducing costs?

Would patients say that the trust's cost improvement activities have adversely affected the quality of care they receive?

How has the board considered the impact of the proposed cost reductions on the community and wider health economy?

6.3 CLARIFYING PRIORITIES AND EXPECTATIONS

Once the board has gained sufficient insight, it should:

- define the priority areas for cost reduction
- set high-level expectations of how management should deliver these priorities.

Initial assessment

Consider the following questions to help decide priorities:

- Does the organisation have:
 - the capacity and capability to manage each cost reduction measure effectively?
 - experience of delivering each cost reduction measure?
- Are people being encouraged to work across boundaries or is the issue seen as a divisional challenge?
- Is there a clear strategy for involving all stakeholders in developing the cost reduction plan?
- Is the cost reduction plan based on a business case underpinned by transparent financial analysis?
- Is the overall allocation of cost reduction targets across the organisation based on relative efficiency of each service area?
- Have key risks been identified for each major scheme and mitigating actions set up?
- How have the cost reduction schemes been framed in the organisation's pursuit of quality?
- Are there clearly defined milestones within the plan?
- Is there clear ownership at both director and project level of the plan?
- What criteria will the board use to decide to stop a cost reduction plan?

Encouraging innovation and productivity

Productivity is achieved via innovation, and today's financial climate calls for innovation. Innovation is also part of the process of clarifying priorities and expectations. The University of Birmingham Health Services Management Centre has compiled a list of suggested strategies to encourage innovation, including:

- build on previous NHS experience

- engage frontline staff and mobilise commitment to change from within
- learn from organisations with a track record of innovation
- value and celebrate innovation and innovators
- foster links with non-NHS organisations.

Framing cost reduction priorities

' If we tackle cost reduction in the way that we have traditionally done, we will look for ways to reduce inputs (staff, facilities, and equipment) or services without fundamentally rethinking the way we deliver care'

Helen Bevan on the pitfalls of NHS cost reduction, HSI, 1 June 2009

In the context of cost reduction, the organisation's priorities and expectations have to be considered within a wider framework of pursuing quality.

Case study

A recent review of an aspirant foundation trust revealed that the workforce implications of a Cost Improvement Plan (CIP) contradicted the forecast assumptions of the trust's staffing model. The trust assumed a number of significant investments with revenue implications, which were contradicted by CIP assumptions that implied cuts in the same area.

The cost reduction schemes had been considered from the staff and patient experience perspective and had significant implications for the staff's ability to deliver high-quality care.

This organisation lacked a coordinated approach linking their cost improvement plan, risk register, workforce plan and business plan.

The financial downturn could also distract boards from maintaining quality standards unless they implement a unified agenda.

Reflection

The risk of prioritising financial performance over quality is clear in the cautionary tale of Mid Staffordshire NHS FT.

The Healthcare Commission found that the board was placing financial performance ahead of service quality and patient safety in order to achieve FT status.

Releasing Time to Care ('The Productive Ward')

Clarifying priorities and expectations includes clarifying how to achieve cost reductions and productivity. A number of boards in London have chosen 'The Productive Ward' as an organisational priority (see case study).

In 2009, Deloitte evaluated the 43 London trusts that implemented 'Releasing Time to Care (The Productive Ward)'.

The findings indicated that, overall, the programme resulted in a measurable positive impact, and that six key factors drove the spread, speed and sustainability of Releasing Time to Care. These were:

1. Leadership engagement – visible leadership from Executives (including CE, Director of Nursing, Director of Service Improvement and Director of Finance) encouraged operational staff to deliver the programme.
2. Strategic alignment – a clear link between the strategic objectives of the trust and the goals of Releasing Time to Care encouraged all levels of staff to support the trust's objectives.
3. Governance – the trust leadership operated a robust governance mechanism, keeping informed of the progress of Releasing Time to Care and identifying where senior intervention was required to resolve issues.
4. Measurement – staff collected and owned appropriate measures, and responded to changes in measurements, ensuring that accurate and timely data were available.
5. Capability and learning – staff knowledge and skills were developed to change work processes and coach others; a culture of shared knowledge grew across organisations and across London.
6. Resourcing (people) – adequate staff time was dedicated to the programme for Releasing Time to Care initiatives to be owned by frontline staff.

'One of the biggest cultural issues we need to tackle is the view that higher quality means higher costs.'

*David Nicholson, HSJ, 12
November 2009*

6.4 HOLDING TO ACCOUNT

Once a cost reduction plan is in place, the board should hold the executive to account by asking:

- Are the anticipated cost savings for each project being delivered?
- Crucially, is quality of service maintained whilst reductions are delivered?

Achieving maximum productivity is the key to unifying the potentially conflicting agendas of cost reduction and quality. Productivity levels in London are lower than elsewhere in England, so this is even more pertinent for London board members.

How would your board respond to the following questions?

Seeking assurance on quality

- How do board members interpret the impact of cost reduction on quality using performance management reports?
- If you have a standalone quality committee (or equivalent), how does it interact with the committee responsible for cost reduction?
- How do the senior managers responsible for cost reduction and quality engage with each other?
- Could any part of a serious untoward incident be attributed to a cost saving scheme?
- Is every cost saving initiative assessed for impact on quality? How is the correlation between quality indicators and cost savings assessed?
- How does your quality strategy incorporate cost reduction?
- Do you have a disinvestment strategy? How does this relate to quality measures?

Measuring productivity

- How does your organisation measure productivity?
- Are there clearly defined milestones within the productivity plans and how are these reported?
- Is productivity measured in every key area relevant to the quality and cost reduction agenda?
- Do you have appropriate benchmarking or comparative information to assess productivity?

- Do you feel assured by the data quality on productivity?
- How are your productivity indicators aligned to 'Better Value Better Care' indicators?
- How are your productivity indicators aligned to the proposals in 'Framework for Action'?

Case study

Northumberland Tyne and Wear NHS Foundation (NTW), a large mental health and disability trust with an annual budget of £300M, prepared for FT status by developing a Cost Improvement Monitoring Framework (CIMF) to ensure oversight of the many cost improvement projects being implemented across their nine directorates.

The CIMF mechanism comprehensively reported on the progress of all initiatives and, critically, identified projects at risk of not delivering the planned cost reduction or missing the agreed timeframe.

1. All schemes were assigned a project type (1, 2 or 3) depending on their size, risk and complexity.
2. Each project was allocated defined guidelines, including processes for project management and project reporting.
3. Each directorate was allocated a Project Board and an accountable ED.
4. Each Project Board reported to the Finance Infrastructure and Business Development Committee and then to the board on a critical risk and associated mitigation basis.

Type 1 Projects: Large standalone schemes within each Directorate

A Project Initiation Document (PID) was produced and a project organisation structure formed.

Specific project controls were developed (such as highlight reports).

The reporting requirement was a project progress report.

Type 2 Projects: Small inter-related schemes

The large number of these smaller schemes significantly increased the level of risk. To address this, inter-related schemes were grouped into projects. Each project required:

- a signed-off PID
- a project structure
- a detailed project plan covering all the smaller schemes.

The reporting requirement was a project report for each project.

Type 3 Projects: Small standalone schemes within each Directorate

These projects required:

- a one-page Project Outline Document
- an accompanying action plan, listing tasks, owners and dates.

The reporting requirement was a copy of the updated action plan for each project.

Oversight

Critical to holding to account is having the right information. Effective oversight of the (often many) cost reduction schemes will enable effective challenge.

Reflection

How does your organisation ensure that the board has sufficient oversight of all the cost reduction schemes in place?

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Further resources

Further reading and support

Adaptive Leadership

Ronald Heifetz and Donald Laurie have written about leaders adapting to change. They describe 6 fundamental principles for leading adaptive work (addressing problems that require a fundamental change in thinking):

Get on the balcony- see or create a context for change

Identify the adaptive challenge – regulate the distress caused by the challenge

Maintain disciplined attention

Give the work back to the people

Protect voices of leadership from below – i.e. the people who point out the contradictions in an organisation are invaluable.

To read more see: The Work of Leadership, Harvard Business Review at <http://hbr.org/2001/12/the-work-of-leadership/ar/1>

Commercial Support Unit

Following national guidance, a Commercial Support Unit (CSU) designed to support all organisations in Quality Innovation Productivity and Prevention (QIPP) and operational efficiency policy priorities has been established in London. The unit is a federation of:

- Commissioning Support for London
- London Procurement Programme
- Commercial Board.

For additional information speak to Sarah Crowther Chair, Commercial Board.

Further reading

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Acknowledgements

This guide has been prepared for NHS London by Deloitte LLP and Pilgrim Projects Limited. We would like to express our gratitude to all those who have contributed to the preparation and review of this guide.

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Neil Boss	Associate Partner, Deloitte
Liz Bradley	Director, Deloitte
Julia Brown	Chief Operating Officer, NHS Enfield
John Bruce	Chair, Southend University Hospital NHS Foundation Trust
Elisabeth Buggins	Director, The National Leadership Council
Miranda Carter	Assessment Director, Monitor
Andy Chittenden	Board Secretary, University Hospital of South Manchester NHS Foundation Trust
Naaz Coker	Chair, St George's Healthcare NHS Trust
Jackie Daniel	Chief Executive, Manchester Mental Health and Social Care Trust
Mark Davies	Chair, NHS London
Natasha De Soysa	Senior Manager, Deloitte
Tony Drabble	Senior Manager, Deloitte
Vic Dulewicz	Professor, Henley Business School, University of Reading
Stuart Emslie	Independent consultant
Sharon Fraser	Board Member, Deloitte
Bob Garratt	Professor, Cass Business School, City University London
Allan Gasson	Partner, Deloitte
Annette Gately	Director HR and OD, Mayday Healthcare plc
Geoff Gibbons	Associate Partner, Deloitte
Nigel Gloudon	Director, Deloitte
Peter Goldsborough	NED at NHS London, Partner at BCG
Felicity Goodey	Chair, University Hospital of South Manchester NHS Foundation Trust
Carol Grant-Garwood	Senior Manager, Deloitte
Mike Griffin	HR Director, Imperial NHS Trust
Kari Hale	Senior Partner, Deloitte
John Hall	Director, Deloitte
Simon Hall	Director Corporate Development, NHS Waltham Forest
Jacqui Harvey	Chief Executive, City and Hackney Teaching Primary Care Trust
Joe Hegarty	Chair, Westminster Primary Care Trust
Penny Hurst	Chair, The Evelina Family Trust

Saghir Hussain	Senior Manager, Deloitte
Nigel Johnson	Partner, Deloitte
Eddie Johnson	Manager, Deloitte
Martyn Jones	Senior Partner, Deloitte
Sam Jones	Chief Executive, Epsom and St Helier University Hospitals NHS Trust
Andrew Kakabadse	Professor, Cranfield University
Paula Khan	Chair, NCL Sector, NHS Islington
Keith Leslie	Partner, Deloitte
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Tracey Long	Director, Boardroom Review
Madeliene Long	Chair, South London and Maudsley NHS Foundation Trust
Jay Lorsch	Professor, Harvard University
Hugh Marshall	Associate Partner, Deloitte
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Michael Richardson	Chair, The Lewisham Hospital NHS Trust
Christian Ruckh	Director, Deloitte
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John Williams	Chair, Blackburn Rovers FC
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