CRISIS IN GOVERNANCE

NHS Governance
A Critical Time for Change

Research Report on UK National Health Service (NHS) Governance

Henley Business School
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Key findings

A new and extensive survey conducted by Henley Business School and supported by the NHS Providers, NHS Confederation and NHS Improvements, finds:

- NHS organisations and their boards continue to face tremendous pressures on resources, resulting in regulatory exhaustion, while also being asked to transform their operations significantly
- In the face of the COVID-19 crisis, the importance of the NHS to the UK's economy and society has been demonstrated in an unparalleled and dramatic way .However these challenges have exposed major weaknesses in the governance and management of our healthcare system
- Boards need to act as strategic stewards that enable important trust level transformations to occur
- 19.1% of non-executive directors (NEDs) surveyed believe the NHS mandate – the standard by which they need to deliver – makes it impossible to perform their role
- 19% of directors surveyed consider their boards are 'average or worse' in terms of the competence needed to face current challenges. A further 16% rate boards as handling awkward and sensitive discussions as 'average or worse'
- NEDs use much of the time they devote to their role (51% contribute 40 or more days each year) on monitoring and control and compliance tasks, despite a requirement to play a more fundamental role in strategic transformation and stewardship
- Some directors are discouraged from helping the executive work through the dilemmas and choices that face them
- The level of information provided to the board is too operational, while greater debate and examination is required on forward looking and strategic issues

- Directors have asked for more “touch points throughout the organisation” and want greater access to ‘best practice’ from across the NHS trusts
- 23% of survey respondents say that chairs are not effective at managing the boundaries between executives and non-executives, and 37% report that chairs are ineffective at dealing with or removing non-performing or disruptive board members
- Non-executive directors are calling for more administrative and IT support, as well as much greater investment in director and board training and development
- A substantial number of NEDs want harmonisation of director pay between NHS Trusts and Foundation Trusts, as well as an overall increase in remuneration, which is currently perceived as very low for the demands of the role
- A review of director pay could be used to boost diversity on NHS boards, which are still severely lagging. Some 94% of directors responding to the survey were from a White/ White British background, and only 42% were female. Both numbers are distant from the wider NHS workforce composition.

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Introduction

If there were any doubts that the NHS is a vitally important public sector service to both UK society and the economy, the COVID-19 pandemic has eliminated them.

However, the challenges facing the health service, including hospitals, care homes, clinics and GPS surgeries are enormous. At the time of writing, there are over 46,000 deaths in England which is one of the worst recorded levels in the world. Over 110 members of staff have died. To say that the impact on staff shortages and morale is very damaging is to drastically understate matters. The Royal College of Nursing[1] stated that the future will be marked by an enormous struggle for burnt-out nursing professionals on short-staffed wards and in care homes. Furthermore, the COVID-19 crisis has dramatically exposed the long-standing issues in care homes, which are the result of gross failure by successive governments to address ongoing problems, including significant under-funding, and a lack of strategy or any clear plan with which to deal with an increasingly elderly population.

Prioritising COVID-19 over all other concerns is, in itself, causing tremendous problems for both the NHS and its patients. The waiting list for other illnesses has grown to 4.2 million and the NHS Confederation is warning that this will further expand to 10 million by the year's end .For example, Cancer UK estimates that 2.4 million people are waiting to be screened for cancer. Beyond this, the mental health consequences for NHS staff and society are only now being uncovered. A recent report from NHS Providers[2] stated that "The levels of 'pent-up demand' for mental health services over the last 10 weeks as GP referrals and patient

[1] RCNI (2020). Exhausted nurses 'will need support to restart services' after pandemic , available at, https://rcni.com/nursing-standard/newsroom/news/exhausted-nurses-will-need-support-to-restart-services-after-pandemic-161846

[2] NHS Providers (2020). The impact of COVID-19 on mental health trusts in the NHS, available at, https://nhsproviders.org/media/689590/spotlight-on-mental-health.pdf

presentations have dropped is of real concern." The crisis has also exposed the chronic and severe inadequacies in the NHS supply chain management which led to a shortage of personal protective equipment for those in the front line of providing care.

The Nuffield Trust[3], in its recent report on the challenges of COVID-19, summarised the magnitude of what is to come:

> "It will inevitably have a large negative impact on the ability of the NHS to deliver what it was able to offer previously. This could mean the public having to accept reduced services, health and care staff facing continued and long term changes to their way of working and difficult changes ahead for policy makers in accepting a degree of rationing of Heath care that would have previously been seen as unacceptable (…) There is no escaping the reality that the dilemmas faced by the Health and social care system will produce tensions that will be extremely difficult to manage."

In view of this information and commentary there is an increasing demand led by the scientific and medical community for a public enquiry conducted by a cross-party group of senior backbenchers from the House of Commons.

Public and political support for investment in the NHS will grow substantially in the aftermath of the pandemic. Decreasing investment or announcing cuts to the NHS in any shape or form will likely be met with public anger and have very real consequences for those who determine this type of action. No government, political party or board of NHS trusts will want to be associated with such highly unpopular measures. However, the pandemic has brought into sharp focus the direction of travel being followed for the NHS, expressed first, in the 5-Years Forward View[4], and now The NHS Long Term Plan[5] – alongside the many Strategic

[3] Edwards, N. (2020). Here to stay? How the NHS will have to learn to live with coronavirus, Discussion Paper May 2020, Nuffield Trust, available at https://www.nuffieldtrust.org.uk/files/2020-06/1591362811_nuffield-trust-here-to-stay-how-the-nhs-will-have-to-learn-to-live-with-coronavirus.pdf

[4] NHS (2014). *Five Years Forward View*. Available at https://www.england.nhs.uk/wp content/uploads/2014/10/5yfv-web.pdf

[5] NHS (2019). *The NHS Long-Term Plan*. Available at https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Transformation Plans (STPs) that are under execution at Trust level. After all, transmissible diseases are far from being under control and hospital-based care needs to remain able to respond to COVID-19-type situations.

There is, however, an enormous positive: the political capital that the current crisis has generated in favour of the NHS can be used to forge cross-party consensus as to the way forward and the core nature of the NHS mandate. However the direction of travel may change. Strong and effective boards of directors at Trust and Foundation Trust levels are required to ensure that the trusts and foundation trusts are effective agents in the strategic transformation that lies ahead.

While many NHS trust have adequately good governance, many others are at risk. There are numerous ways in which NHS boards can improve, not least, by playing a much greater engaged stewardship role than is currently the case. This report contributes to this discussion by analysing the findings of a survey carried out by Henley Business School, with the support of NHS Providers, NHS Confederation and NHS Improvements during 2018-19.

The survey returned 203 responses from non-executive and executive board directors across NHS Trusts and Foundation Trusts, and the results are discussed in conjunction with interview material carried out with experienced NHS chairs, CEOs, and other NHS directors' qualitative comments made throughout the survey process.

The report is structured as follows: The first section discusses the challenges and risks facing the NHS sector in the UK, contrasting this with the findings from the Henley survey. Particular attention is given to how board members assess their board competence to face up to these challenges. The subsequent two sections discuss board director's diversity and experience. The fourth section discusses independent board members' quality and degrees of engagement, and their overall contribution to the board. The role and practice

effectiveness of the chair of the board is also considered and the Report concludes with a set of recommendations for the reform of NHS Trusts and Foundation Trusts governance. **Appendix 1** provides more detail on the methodology.

I. NHS challenges and the post COVID-19 UK: where do we go from here?

In October 2014 the NHS published "The Five Year Forward View" a document that mapped out the challenges facing the NHS and laying the foundations for transforming the NHS to meet the future.

The document was said to represent "the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities, and frontline NHS leaders" (NHS, 2014: 2).

The Five Years Forward has pledged to tackle widespread variations in quality of care, preventable illness, overall health discrepancies, and address changing patient needs. Not least of these are the requirements of elderly patients, and the pressures being placed on services relating to mental health and cancer. Improvements in all of these areas are to be achieved while NHS efficiency improves.

This results in three fundamental NHS "gaps" to address:

i) *Health and wellbeing gap* (investing more in effective prevention / public health to reduce health inequalities, fund new treatments and spend less on treating avoidable diseases)

ii) *Care and quality gap* (new models of care delivery to meet changing needs while weeding out quality variability)

iii) *Funding and efficiency gap* (matching reasonable funding levels with wide ranging system inefficiencies).

However, actual delivery against all three of these gaps has been limited to date and realisation of a shared vision for the future NHS remains a distant ambition.

For example, a recent paper by the British Medical Association (BAM, 2018) on *Funding for ill-health prevention and public health in the UK* shows that public health expenditure in England, which accounts for approximately 5% of total health spending, will be reduced from £3.47 billion in 2015/16 to £3.07 billion in 2020/2021.

This clearly illustrates that the health and well-being gap is not being addressed effectively. Prevention is key in enabling real progress in the other two "gaps" and should be made without risking service quality or patient safety across the system. Additionally, an analysis of 44 sustainability and transformation plans[6] (STPs) in the NHS in England developed by trusts and foundation trusts to implement the five-year forward view revealed eight major themes[7]. However, these themes vary in quality and completeness across STPs, most notably in prevention and early intervention.

Alderweick and Ham, debunk some of the key assumptions that profoundly challenge the feasibility of implementation. One such assumption contained in the plans is *the ambition to reduce capacity in acute hospitals*, countered by the reality of acute hospitals operating at full capacity while demand rises further, not least because of the COVID-19 pandemic.

[6] Alderweick, H., and Ham, C. (2017). Sustainability and transformation plans for the NHS in England: what do they say and what happens next? *British Medical Journal*, 77.

[7] The themes are: i) redesigning primary care and community services; ii) changing the role of acute and community hospitals; iii) strengthening prevention and early intervention; iv) improving care in priority areas, such as mental health; v) improving productivity and tackling variations in care; vi) supporting and developing the workforce; vii) improving IT, estates and other "enablers"; viii) organisational changes to support STPs.

The authors explain that any reduction in acute hospital capacity can only be possible if substantial investment is made in care outside of hospitals. Yet "this investment is currently lacking. Additional funding for the NHS is being primarily used to reduce hospital deficits, leaving little scope to develop new care models" (p. 2).

Other problematic assumptions include *the time it takes to implement STPs* which is "underestimated, and their impact overestimated" and *the feasibility of achieving financial balance by 2020-21*, which is seen as the most important priority contained in STPs by chairs and chief executives[8] , although analysis shows that achieving financial targets will range from challenging to impossible[9].

To be clear, the NHS Improvements report[10] on the performance figures for the NHS provider sector for the quarter ending June 2018 confirms just how problematic these assumptions are: the ambition to freeing bed capacity in acute hospitals "remains challenging"; providers failed in aggregate to achieve waiting time standards for 14 out of 15 key diagnostic tests; providers continue to struggle to achieve financial targets and future stability, due to operational pressures essentially caused by cost pressures relating to temporary staffing and substantive workforce pressures; savings relating to agency staff spending are under control, but there are high levels of vacancies that are difficult to fill (108,000 vacancies existed by June 2018).

8 NHS Providers (2016). The state of the NHS provider sector. Available at www.nhsproviders.org/resource-library/reports/state-of-the-nhs-provider-sector-1116

9 Gainsbury, S. (2016). Feeling the crunch: NHS finances to 2020. Nuffield Trust.

10 NHS Improvement (2018a). Performance of the NHS provider sector for the quarter ended 30 June 2018. Available at https://improvement.nhs.uk/documents/3209/Performance_of_the_NHS_provider_sector_for_the_month_ended_30_June_18_FINAL.pdf

While the NHS Long-term plan published in 2019 attempted to tackle some of the issues faced with the five-year forward view, the direction of travel has not changed and the structural issues remain the same. It is no surprise that the Henley survey found that NHS boards continue to face substantial challenges **(Table 1)**

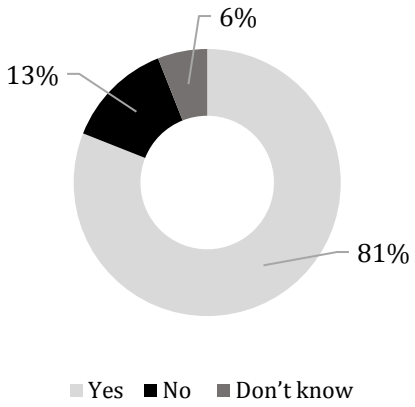
Table 1: NHS Board challenges (% of respondents placing the challenge in top-5)

Challenges facing the NHS	Total
Balancing quality with limited resources	62%
Under-staffing issues	61%
Delivering against targets with limited resources	43%
An ageing population	41%
Outdated health model rooted in the 20th century (change from hospital-based system to a community-based system)	39%
Trying to satisfy multiple demands / priorities	34%
Lack of financial resources	33%
Coordination between hospitals and local authority services	27%
Increasing prevalence of modern day diseases / lifestyle issues (e.g. obesity, diabetes, mental illness, dementia etc.)	24%
Stretching of resources during winter periods	23%
New digital technologies related to healthcare	20%
Heavily regulated sector	20%
Poor morale and employee engagement	15%
Performance inefficiencies / inadequacies	14%
The new partnering model	13%
Lack of exploitation of innovation opportunities	13%

Source: Henley Business School Survey (2018)

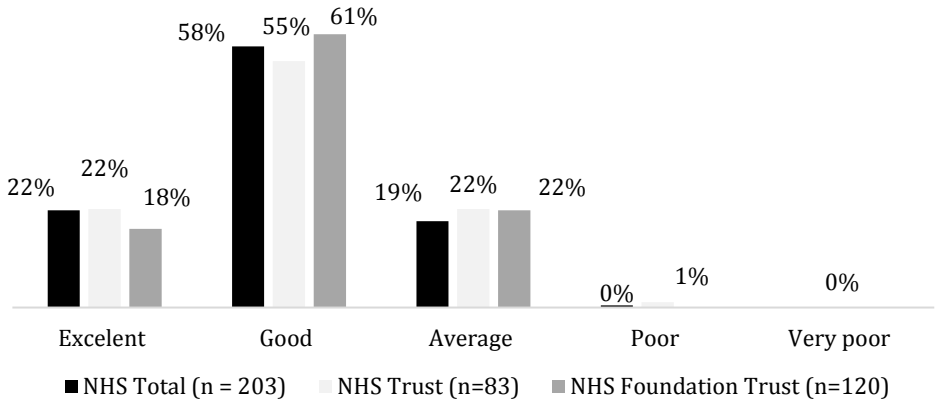
NHS directors continue to face the tremendous challenges of being required to achieve efficiency demands and maintain service reach and quality (62%), while also delivering on fundamental transformation to a different care model (39%) to address an ageing population (41%). Facing such an insurmountable task a sizeable number of NHS directors (13%) believe it is “impossible to perform well in their role while delivering against the challenges of the pre-existing mandate within the NHS,” or do not have an opinion (6%) **(Figure 1)**.

Figure 1: Possible to perform role effectively while delivering against the challenges of the existing mandate within the NHS (n=203)



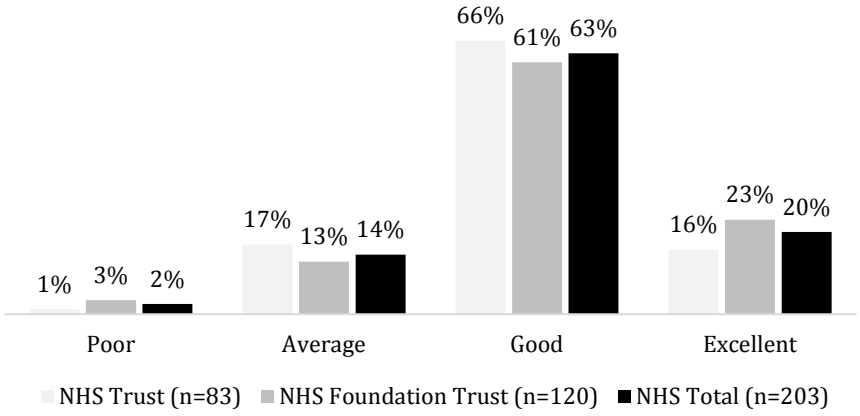
Not only do a significant number of NHS board directors think it is impossible to be effective in role fulfilment given the challenges of the NHS mandate, an even bigger percentage (19%) believe their board's competency to handle the challenges faced is only average **(Figure 2)**.

Figure 2: NHS Boards competency to handle challenges faced (n=203)



In addition, 16% of NHS directors surveyed consider their board to be average or worse in handling sensitive and awkward discussions **(Figure 3)**. Boards that lack the necessary competency and are unable to face issues within highly complex and constrained environments are much more likely to fail.

Figure 3: NHS Boards ability to handle sensitive and awkward discussions (n=203)



The COVID-19 crisis has thrown a stark spotlight onto the NHS and its boards. It has also brought into question some of the assumptions that form the basis of NHS transformation plans, specifically – that transmissible diseases are either under control or a thing of the past. It is clear that the NHS needs fundamental transformation and a thorough re-think of its strategic direction. To do so requires political consensus and strong, competent trust-level boards that can play a much larger strategic and stewardship role.

II. Board composition: diversity and experience

The NHS governance benefits from an overlapping array of guidance which, to a large extent, is inspired by the UK Code of Corporate Governance[11] issued by the Financial Reporting Council (FRC) for listed firms.

The Foundation Trusts Code[12] shares with the FRC Code a principle-based 'comply or explain' approach. Other similarities include: a requirement that a unitary board is established, composed of at least 50% independent non-executive directors; mandating that chair and CEO positions are occupied by different individuals, and the board must be composed of individuals with a range of experiences, skills and backgrounds. NHS Trusts are encouraged to make similar arrangements with the regulator[13]. Despite these provisions NHS organisations still need to make progress on director gender balance **(Figure 4)** and most notably on director ethnicity **(Figure 5)**.

Figure 4: Board Directors Gender (% of respondents, n=203)

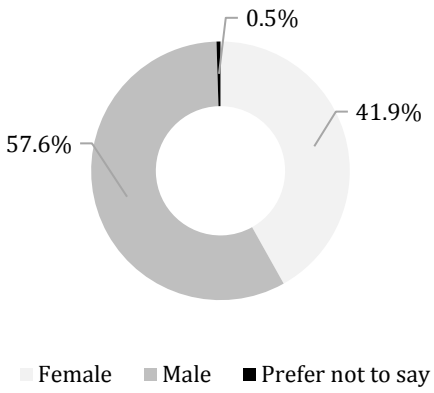
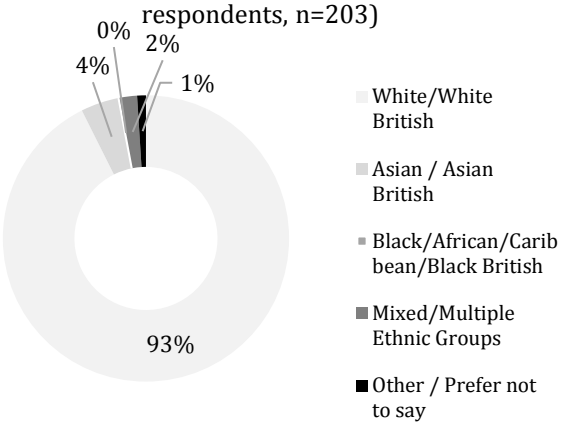


Figure 5: Director Ethnicity (% of respondents, n=203)



[11] Financial Reporting Council (July, 2018). The UK Corporate Governance Code. Available at https://www.frc.org.uk/getattachment/88bd8c45-50ea-4841-95b0-d2f4f48069a2/2018-UK-Corporate-Governance-Code-FINAL.pdf

[12] See Monitor (2014). The NHS Foundation Trust Code of Governance, available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf

[13] NHS Providers (2015). The Foundations of Good Governance: a compendium of good practice, 3rd Edition, available at http://nhsproviders.org/media/1738/foundations-of-good-governance-web-file.pdf

Nearly 42% of respondents to our survey were female and 58% male. These numbers are not reflective of the wider NHS workforce, which as of March 2019 showed 77% of staff as female, and 23% male. This number drops for very senior managers roles, where only 47% were women[14]. It would appear that females face a much tougher journey to reach senior management and leadership positions, despite making-up the vast majority of roles in their organisations.

The state of affairs with regards to the diversity of board directors' ethnic backgrounds is far worse. In the Henley survey 93% of the 203 respondents were from White/White British backgrounds, 4% from Asian/Asian British, 2% from other mixed/multiple ethnic groups and there were no respondents from a Black/African/Caribbean/Black British backgrounds.

Again these numbers are unrecognisable when compared to the reality of the wider NHS workforce's ethnic composition. As of March 2019, 79.2% of the NHS workforce were from a White/White British background, 10% were Asian/Asian British and 6.1% were from a Black/African/Caribbean/Black British background.

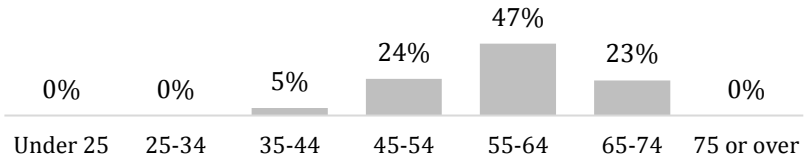
In medical roles, the percentage of staff from a White/White British background drops significantly to 55.6%[15]. Surprisingly, only a handful of respondents considered board diversity to be an important area of improvement in NHS board governance. As one director noted:

> "Wider breadth of backgrounds/experience of non-executive directors (NEDs). Criteria tends to favour people from similar backgrounds."

[14]For complete statistics on NHS workforce gender diversity see http://nhsemployers.org/-/media/Employers/Documents/Plan/Diversity-and-inclusion/EQW19/Gender-in-the-NHS-infografic.pdf

[15] For complete statistics on NHS workforce ethnic diversity see https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#main-facts-and-figures

Figure 6: Directors age range (percentage of respondents, n=203)



In terms of director age, 94% of respondents are more than 45 years-old, with the majority being between 45 and 54 (47%), and close to a quarter (23%) are 65 to 74 years-old.

The emerging picture of director's board experience reveals another area which could be strengthened. It is important that directors overseeing complex and critical organisations like NHS trusts can draw from a wealth of experience **(Figures 7 and 8)**.

Figure 7: Non-executive director Length of Service (Percentage of respondents, n=97)

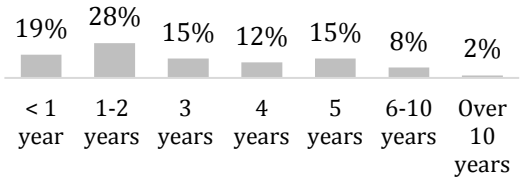
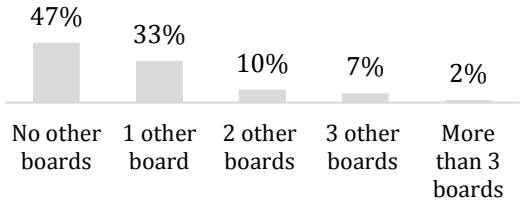


Figure 8: No. of additional directorships held by NHS NEDs (Percentage of respondents, n=97)



Around 47% of respondents have two or less years' board service, while a further 10% possess over six or more years. One Henley survey interviewee commented:

> "As it is a complex sector, a certain amount of time on the board is essential before being able to add value (on the whole). Relationships and skills take a bit of time to build."

In terms of having more general board experience a concerning 47% sit on no other boards. This means that they are unable to inform their NHS board position from any other kind of comparable position. Many directors expressed a desire to be in contact with good practice elsewhere, especially within the NHS, and made observations including:

"More exposure available for NEDs to visit high performing organisations."

"Opportunity to know what good looks like in a real time situation/scenario and understand."

"Sharing of lessons learnt, best practice and cross fertilisation across trusts."

In contrast, 10% sit on two other boards, and 9% have experience on three or more other boards. It appears that some of these directors are struggling to meaningfully and diligently fulfil their director responsibilities across this portfolio.

III. Non-executive board members too engaged with compliance?

A key question asked by the Henley survey related to the time spent by non-executive directors on board affairs and specific board-related tasks. NHS board meetings occur more frequently than in many other types of organisations, with 73% of respondents having ten or more board meetings each year. For 50% of respondents board meetings last five or more hours; 30% report that board meetings last six hours or longer, and 28% have shorter meetings of up to three hours (**Figures 9 and 10**, below).

Figure 9: No. Board Meetings / Year
(Percentage of respondents, n=203)

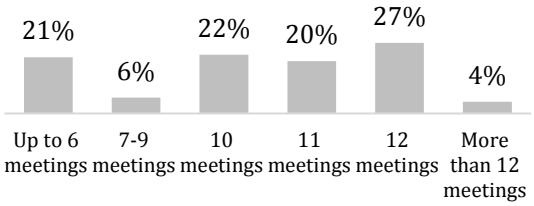
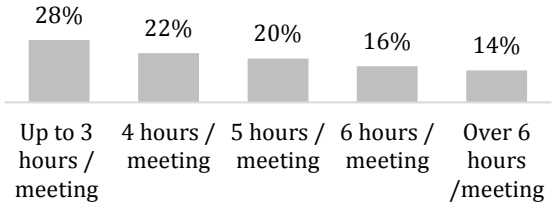


Figure 10: Board Meetings Duration
(Percentage of respondents, n=203)



An important finding from the Henley Survey is the amount of time NHS non-executive directors are devoting to the role as well as where that time is spent. On average NHS NEDs

commit far more time to the role than many other organisations, including large publicly-listed firms.

About 87% of respondents spend two or more days each month in the role; 51% spend three or more days per month, and 28% four or more days a month **(Figure 11)**. Such a high time commitment can easily create tensions with the executive team, which may perceive 'too much interference.' But where do NHS directors spend this time?

Figure 11: Non-executive director Days/Year spent in the role (Percentage of respondents, n=97)

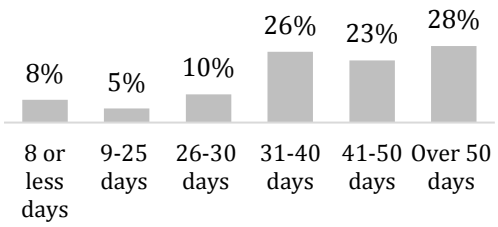


Figure 12: NED time Spent on Monitoring/ Control vs. Stewardship / Strategy Tasks (n=97)

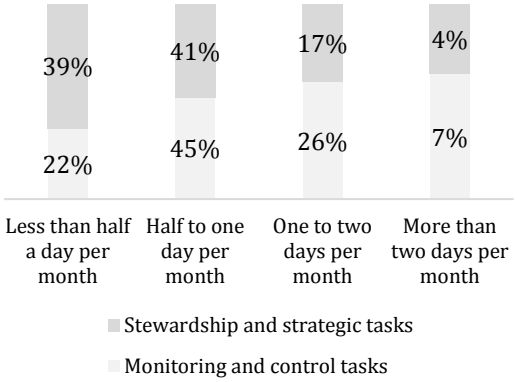


Figure 12 shows that directors tend to spend more time on monitoring and control tasks (including auditing, compliance, monitoring and performance), than on strategic and stewardship tasks (strategic direction, communicating with key stakeholders, succession planning, mentoring and supporting the executive). In fact, some 33% of respondents report spending over one day a month on monitoring and control tasks, compared to just 21% for strategic and stewardship activities.

The Governance code for NHS Foundation Trusts has a much greater focus on monitoring performance and risk and a sizeable number of NHS directors express their concern with "too much external interference" and regulatory exhaustion:

> "[There should be] a greater ability to focus on strategy but despite rhetoric around this purpose NEDs are actually expected to know detail by, for example, the CQC."
>
> "There seems to exist an assumption that the management of all of the issues facing a Board are within their gift to resolve. In much challenged organisations, this is not the case as a large amount of decision making is done by regulators, not the Board".
> "[There needs to exist] more transparency and honesty between NHS central leadership and control, and the notional independence of Trusts".

However, the Code also accords a strategic role, establishing that the board "should develop and articulate a clear vision for the trust… a formally agreed statement of the organisation's purpose and intended outcomes which can be used as a basis for the organisation's overall strategy" (Monitor, 2014, p.16).

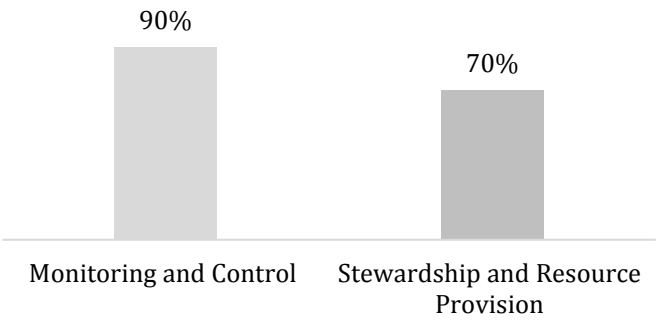
Furthermore, National Leadership Council guidance[16] clearly states that the role of the NHS board is that of "formulating strategy and shaping culture." It says that the strategy development process should "ensure that the strategy is demonstrably shaped and owned by the board" (p.10). This raises an important question – given the simultaneous demands for NHS operational efficiency, care quality, patience safety and transformation and innovation in care models and delivery strategies, is this the right balance for the board? Many directors have expressed concern with the amount of time devoted to monitoring compliance:

> "Better balance between operational and strategic issues would mean time commitment would be less onerous."
>
> "Create more strategic time. Move on from concentrating exclusively on assurance function."
>
> "Clearer, and better quality, accountability and performance discussion and management by the Executive so that the Board can focus on strategy and strategic risks, not the minutiae of operational detail."

[16] National Leadership Council (2013). The Healthy NHS Board Principles for Good Governance. Available at https://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf

To compound matters further the issue is about more than spending less time on stewardship and strategy tasks when compared to monitoring and control tasks. Non-executive directors are also seen as substantially less effective in stewardship and strategy tasks **(Figure 13)**.

Figure 13: NED Role Effectiveness (percentage of respondents agree/strongly agree, n=203)



While 90% of respondents agree/strongly agree that NEDs are effective in monitoring, control and scrutiny behaviours, only 70% believe them to be effective in stewardship and resource provision behaviours – this includes supporting the CEO and executive team, bringing valuable resources and networks to the board, acting as an effective bridge between the organisation and the outside world, and acting as an effective mentor or advisor by assisting the executive team and board through dilemmas and difficult situations.

In fact, directors have expressed that a greater strategic and stewardship role is currently discouraged:

> "Involving the NEDs in the development of the Executive team - we are currently strongly discouraged from mentoring the Executives despite a lot of useful experience".

At this point we have established that NHS non-executive directors spend a substantive amount of time in the role, focusing primarily on monitoring, control, compliance and operational tasks, often at the expense of strategic and stewardship activities. In part this is due to how the NHS Code and regulatory structure operate, limiting NHS trusts and Foundation Trusts' autonomy.

Directors have expressed "regulatory exhaustion" which limits boards' discretion to act in a more contextually-sensitive manner. It is also due to a lack of NED role clarity that still permeates many NHS organisations, both at board and executive team level.

It has been shown that NEDs are seen by themselves and others as being less effective in stewardship and strategy roles. **Table 2** summarises NED engagement and access to high quality information, provided by management and other information sources, as a condition to be effective in challenging and supporting the CEO and executive team.

Table 2: Board practices on evidence-based NED engagement

Use of Data / Evidence	NHS (n = 97)
To familiarise myself with the organisation I often visit operations and talk to other layers of management	78%
To ensure the quality of information is credible, other Directors / Managers or an external expert / advisor is often brought in to present to the board	78%
I have an effective dialogue with the other non-executive directors, to cross-check information and ensure that the data / evidence is robust	95%
I work with the other non-executive directors to ensure that appropriate action is taken at board level based on available data / evidence	94%
I believe I am given all the data / information necessary for the board agenda to play an effective role during meetings	84%
The Chief Executive is open and transparent in ensuring that all relevant information is shared / made readily available	93%
I can effectively analyse data / information by focusing on the key messages	86%

The ability of non-executives to access high quality information is a fundamental necessity for them to discharge their monitoring and stewardship roles. Visiting wards and talking to other layers of management is an important way that NEDs can gather and use first-hand information, separate from the management-fed process.

Equally important is having internal or external managers and experts, other than the executive, who can present before the board. This provides NEDs with the opportunity to cross-check evidence and hear from different parts of the organisation, giving access to

contextually-informed detail and allowing the executive to be challenged as and when is necessary.

Despite this, only 78% of respondents report that they have benefited from such practices on a regular basis. A meaningful number of directors commented:

> "More touch points across the organisation (outside the boardroom)."
>
> "Better understanding of frontline pressures and better visibility in Trust."
>
> "Greater ability to triangulate information received in reports to the reality in the wards."

With regards to data and information provided by the executive team 84% of NEDs believe they are "given all the data/information necessary for the board agenda to play an effective role during meetings," while 86% believe they can "effectively analyse data/information by focusing on the key messages." Qualitative comments received on the questionnaire, however, indicate this is an important area of improvement, emphasising the requirement for more forward-looking, rather than historical, data:

> "More forward looking, dynamic and meaningful data on which to make decisions."
>
> "Less time in committee receiving formal papers so more time can be spent with staff and service users to understand better the challenges etc. and what solutions are required."
>
> "Quality (needs improvement) and quantity (hundreds of pages) and forward thinking (not enough) of papers for board and committees".

IV. The role and practice effectiveness of the NHS Board Chair

This report now focuses on the NHS Board Chair role and practice efficiency – both areas of significant importance to board and NED effectiveness. One chair commented:

> "[…] more chairs need to appraise and set objectives for their NEDs, including personal development objectives and including proactively supporting the next generation of chairs".

Overall this study found that the NHS chair role and practice is seen to be effective, and no statistically meaningful differences were found between NHS Trusts and Foundation Trusts (**Table 3**).

Table 3: NHS Chair Role and Practice Effectiveness (% of respondents agree/strongly agree)

Chair Role and Practice	NHS Trust	NHS Foundation Trust	Total
Creates a shared purpose, values and norms of behaviours that guides the future of the Board / organisation	90	90	90
Establishes the boundaries between non-executive and executive, and is prepared to cross them if necessary	77	77	77
Promotes non-executive director only meetings to discuss issues, share ideas and thinking, and gain greater alignment	72	86	80
Ensures there is an appropriate level and quality of information for debate	90	82	85
Effectively deals with / removes non-performing or disruptive board members	64	63	63
Takes responsibility for board composition	89	90	89
Conducts a thorough annual appraisal of the Chief Executive	89	94	92
Effectively takes responsibility for the composition of committees and how they operate	85	82	83
Ensures that the board is independently evaluated on a regular basis	77	80	78
Has effective relations with external stakeholders	93	89	90
Instils confidence in key stakeholders about the way the organisation is run	89	85	86
Is effective in times of crisis (e.g. bad publicity / a scandal affecting the reputation and image of the organisation / sector)	88	76	81
Has positive relations with the media	59	55	57
Effectively maps board skills against the challenges the organisation / board faces	80	78	79

There are, however, a number of areas of role and practice where chairs need to improve. In the first instance some 20% of respondents (28% in NHS trusts) say that chairs do not promote NED-only meetings to discuss issues, share ideas and thinking, or generate greater alignment. This is an important omission that otherwise would better focus NED activity, cross-check information, make better use of time and prove a more effective method of challenging and supporting the executive. One director stated:

> "[I suggest] More time spent together outside of formal meetings to allow longer and openly/free debate and discuss our concerns or just issues we'd like to mull over."

Secondly, 23% of respondents say chairs are not effective at establishing the boundaries between executive and non-executive, and should be prepared to impose or cross this line as and when is necessary. This is a typical tension in boards and something that, if not effectively managed, can result in negative behaviours from executives and non-executives resulting in far-reaching outcomes. Survey respondents commented:

> "The issue is a broader one about the NHS and whether the line is drawn in the right place between an executive and non-executive."

> "It is key that executives understand the intent of the NEDs and vice versa. Without this, relationships deteriorate and executives act in underhand ways to circumvent the process. This untethers action from purpose and results in negative short-term behaviours."

Thirdly, 37% of respondents indicated that chairs are not effective at dealing with or removing disruptive or non-performing board members. Other areas of improvement for NHS chairs, include:

i) Ensuring the board is independently evaluated

ii) Effectively mapping board skills against the challenges the organisation and boards face.

Chairs play a fundamental role in transforming the board and are primarily concerned with monitoring, control and compliance. However, they also need to place more of their focus on strategic stewardship and transformation. While on the whole chairs are effective at what they do, they need to recognise their role and priorities must change.

V. Improving board effectiveness in the NHS to deliver required transformation

It is clear from the Henley study that NHS boards are operating beneath their potential and play too much of a monitoring, control and compliance role. The plethora of regulatory bodies and pressures created by diminishing budgets and increased demand from an ageing population, are driving boards into an extremely challenging and, to some, impossible position.

Boards need to be more than just an extension or servant of regulatory and oversight bodies of the time. Instead, they need to become the catalyst and strategic stewards who lead on the implementation of frameworks of future change in NHS organisations.

In order to achieve this the Henley study summarised by this report suggests a number of key recommendations:

1. **Review and clarification of the mandate and strategic direction of the NHS**
2. **Review, simplify and harmonise the mass of sector regulation** into a clear framework which is less demanding of board time, creating greater autonomy and discretion at NHS Trust and Foundation Trust board level
3. **Clarify and recalibrate the role of the board,** placing greater emphasis on strategic and stewardship roles while creating a mandate and conditions for boards to enable strategic change, mentoring and coaching executive teams through strategic dilemmas, difficult situations and implementation issues

4. **Determine NED engagement policies** in line with the reality of the organisations they oversee, including enabling greater exposure and good practice from across NHS organisations
5. **Board information and communication technology.** Investment to reduce the burden for NEDs in terms of information processing through training and technology that allows them to deep-dive into information and benefit from more strategic, forward-looking data
6. **Develop an NHS-wide board / NED development Programme** that supports a shift to a more strategic and stewardship role of the board and its members
7. **Pay and board diversity.** Harmonise NED pay across trusts and foundation trusts and use pay policy in conjunction with more inclusive selection criteria that addresses the diversity agenda while also increasing the quality of applicants.

Appendix 1: Methodology and sample characteristics

This report is a small part of a 2-year research programme conducted by a team of researchers at Henley Business School.

The team has conducted in-depth qualitative interviews with 43 key opinion leaders (e.g. chairs, VCs, CEOs, independent directors) across the NHS, charity, sports, and university sectors. The interviews explored board governance across these sectors and focused on independence and the independent director role. It asked one key question: How can independence be gained, sustained, and lost? The ensuing report identified a number of themes and insights that subsequently formed the base for the survey design. The survey was tested with directors both face-to-face and online to eliminate ambiguities and duplications, and to clarify questions. After this process, the length of the survey was substantially reduced. The final version of the survey was also discussed with key stakeholders in each sector who have made some final suggestions.

The NHS Providers, NHS Confederation and the NHS Improvements supported the Henley team by distributing the survey online to as many NHS Trust boards as possible.

The survey was sent to directors in each of these sectors. The survey returned 623 completed responses from across the 4 sectors mentioned above. For the NHS, the number of completed surveys was 203. There was a good spread in terms of trust type, size, and respondents' role (see below for details on key sample characteristics).

Figure 14: No. of Respondents by type of NHS organisation

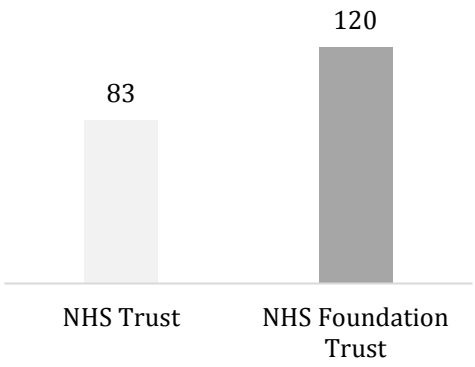


Figure 15: No of Respondents by organisation size

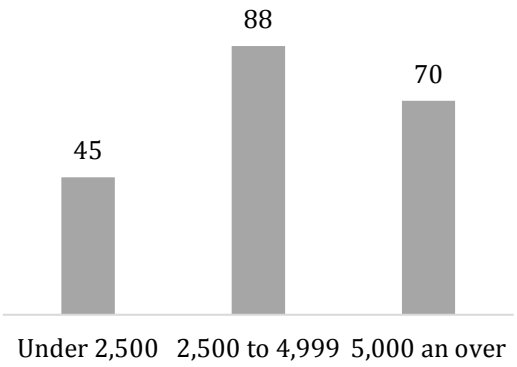


Figure 16: No. of Respondents by Role