Overseeing oversight:
Hospital Board governance of quality and safety in the English NHS

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Abstract

Objectives

To contribute towards an understanding of hospital Board composition and oversight of patient safety and health care quality in the NHS.

Methods

A review of the theory related to hospital Board governance and two national surveys undertaken about Board management in NHS acute and specialist hospital trusts in England. The first was issued to 150 Trusts in 2011/12 and completed online *via* a dedicated web tool. A total 145 replies were received (97% response rate). The second online survey undertaken in 2012/13 targeted individual Board members using the BSAQ questionnaire. A total of 334 responses were received from 165 executive and 169 non-executive board members, providing at least one response from 95 of the 144 NHS Trusts then in existence (66% response rate).

Results

Around 42% of Boards had 10-12 members and around 51% had 13-15 members. We found no significant difference in Board size between Trusts of different types. Around 62% of Boards had three or fewer serving Board members with clinical backgrounds. For about two-thirds of the Trusts (63%), Board members with a clinical background comprised less than 30% of the Board members. Boards were using a wide range of hard performance metrics and soft intelligence to monitor their organisation with regard to patient safety. Hard, quantitative data were reportedly used at every Board meeting across most hospital Trusts (>80%), including a range of clinical outcomes measures, infection rates and process measures such as medication errors and readmission rates. A much smaller proportion of Trusts (57%) routinely report morbidity rates at every Board meeting. Softer intelligence, used organisationally and reported at all Board meetings, was more variably reported, with discussions with clinicians (in 89% of Trusts) and executive walk-arounds (88%) being most often reported, alongside use of patient stories (83%). However, in only about two-thirds of Trusts did Board members shadow clinicians and report back to the Board (65%). The BSAQ data showed general high or very high levels of agreement with desirable statements of practice in each of the six dimensions. Aggregate levels of agreement within each dimension ranged from 73% (interpersonal) to 85% (political).

Conclusions

The study provides the best account to-date of English NHS Boards and their actions around health care quality and patient safety. It thus lays the groundwork for further empirical research exploring the dynamics, influences and impacts of Boards.

Introduction

Hospital Trust Boards in the English NHS have statutory responsibility for upholding the quality and safety of care delivered by their organisation. However, recent high-profile reports into serious failings in the quality of hospital care in the NHS raise serious concerns over the ability of hospital Trust Boards to discharge these duties effectively [1, 2].

Most recently, the report of the Public Inquiry into Mid Staffordshire NHS Trust estimated that up to 1,200 people had died unnecessarily in the period 2005-2008 and concluded that the suffering and neglect of patients was primarily caused by a serious failure on the part of the hospital Trust Board which *'did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and disengagement from management and leadership responsibilities.'* [2]. Similar failures in hospital Board leadership and governance are a recurring theme of earlier inquiries into hospital scandals in the English NHS, including the tragic events at Bristol Royal Infirmary in the 1990s and date as far back as the late 1960s with the inquiry into the mistreatment of long stay patients at Ely hospital. [3]

The role of hospital Boards in the English NHS
Hospital Boards in the English NHS have traditionally operated along the lines of the Anglo-Saxon private sector unitary board model [4, 5] which typically comprises a chair, chief executive, executive directors and non-executive directors who are, with the chair, in the majority. All board members share corporate responsibility for formulating strategy, ensuring accountability and shaping culture. However, there are also distinctive roles for members of the Board: the Chair leads the Board, taking overall responsibility for the effectiveness of Board processes (and for Foundation Trusts, the Chair also chairs the Council of Governors). Alongside the Chair, the Chief Executive leads the executive functions within the organisation, taking overall responsibility for service delivery.

At the end of 2013, 147 out of 230 NHS providers in England (64%) (including acute and mental health hospitals and ambulance services), operated as NHS Foundation Trusts (FTs), which have greater freedoms from other types of hospitals and are based on co-operative and mutual traditions. [6] Governance arrangements in FTs are locally determined within a national framework, and non-executive Board members are appointed by the governors of the hospital, rather than by the NHS Appointments Commission.

Guidance for Boards
Despite a plethora of guidance available to NHS Boards on effective governance both in general terms (e.g. structure and role), and with specific reference to safer care – significant gaps remain in our understanding of what Board governance looks like, and the organisational processes through which safe care is accomplished and sustained. A recent international review of the theory and evidence highlighted a number of plausible relationships between hospital Boards and health care quality, but concluded that much remains to be explored, empirically and conceptually. [7]

Empirical work in the NHS is sparse. Drawing on information from English NHS Trust websites, Pritchard and Harding, [8] highlighted the dominance of business, accounting and

finance as the key background expertise found in NHS Board chairs (almost three-quarters fit this background). They also noted the paucity of non-executive directors (NEDs) with clinical backgrounds (less than 10% of NEDs), and only half of Trusts (52%) had *any* NED with clinical experience.

Other work suggests that the presence of clinical expertise on Boards (especially doctors) may be important for hospital-level outputs and outcomes. [9] Previous research in the US has shown that high-performing hospitals have a number of Board-related features: they typically have a specific quality subcommittee; they have greater expertise and formal training in quality; quality is reported as a higher priority for board oversight and CEO performance evaluation.[10]

Learning more about Boards in the English NHS
Overall though, we lack an understanding of Board composition in the English NHS, and of what Boards actually *do*, especially in relation to promoting patient safety and quality. So for example what percentage of Board time is spent discussing quality and patient safety issues? What information (hard and soft) do Boards review on a regular basis to assess whether they are providing safe care? What proportion of Board members are trained in patient safety? How are Boards composed and structured in terms of clinical involvement and engagement? In particular, beyond broad occupational backgrounds, we lack detailed information on the range of competencies of hospital Board members and how these relate to safeguarding care. Without such insights we are hampered in understanding Board roles and influences in the NHS.

In this article we first explore some of the key theoretical frameworks that can be used to understand hospital Board governance in relation to patient safety, and we then present a contemporary account of English NHS Boards drawing on recent data from two surveys.

Theories of Board behaviour
Several theoretical frameworks of Board governance have been developed, and here we make the distinction between whether Boards are conceptualised in either *instrumental* or *symbolic* terms. Guidance on the role and conduct of NHS Boards is most usually informed by instrumentalist assumptions of the role of Boards as fora for deliberation, conciliation and decision-making. On these terms a 'successful' Board is one that is able to take decisions on corporate strategy in an efficient and effective manner, and can monitor its implementation through to organisational success. Four key instrumentalist frameworks can be discerned in the literature:

i) *Agency theory* works on the assumption that, unless scrutinised, staff will seek to pursue their own interests rather than wider organisational objectives (opportunism). Here the Board is conceptualised as a monitoring device set up to ensure compliance by developing systems of checking, monitoring and control to hold staff accountable for their actions. This approach has previously been used to understand and classify clinical governance strategies in UK hospitals.[11]

ii) *Stewardship theory* assumes that staff are motivated by more than their own narrow self-interests, and that managers want to do a good job and serve as effective stewards of an organisation's resources. [12] The theory assumes a high

degree of trust, with the focus of the Board being on creating a framework for shared values and enabling staff, rather than monitoring and coercing performance.

iii) *Stakeholder theory* assumes a multiplicity of competing and cooperative interests within organisations, and focuses on how various stakeholder interests can be addressed, integrated and balanced. [13] The role of Board members is then to understand and represent the views of all those with a stake in the organisation, and it is recognised that the Board may need to manage complex trade-offs between stakeholders, including staff, patients and the public.

iv) *Resource dependency theory* derives from the strategic management literature and was originally developed particularly by Zahra and Pearce. [14] From this perspective the organisation is seen as an amalgam of tangible and intangible assets and dynamic capabilities. The main function of the Board is to successfully manage internal and external relationships to leverage influence and resources. Board members are selected for their background, contacts and skills in mediation and 'boundary spanning.'

In spite of their differences, all four of these instrumentalist theories assume that Board members are able to exercise influence over staff, and that it is through this influence that they are able to bring about change and enhance organisational performance. Integrating insights from both agency and stewardship theories, Garratt [4] posits two main dimensions of Board attention, which he terms 'conformance' and 'performance' (see Figure 1). *Conformance* can be focused externally or internally: *external accountability* includes compliance with legal and regulatory requirements, as well as accountability to external stakeholders, while an *internal* focus involves supervision and management controls. The conformance dimension thus aligns with the agency theory perspective on governance. In contrast the *performance* dimension of Board attention, according to Garratt [4], concerns driving the organisation to better achieve its objectives and goals. This again consists of two main functions: *policy formulation* and *strategic thinking*. The performance dimension is more closely related to the stewardship theory of corporate governance. This framework suggests that Boards need to be concerned with both the conformance and performance dimensions of corporate governance, and that blended perspectives on agency/stewardship may be necessary.

<<Figure 1 about here>>

Symbolic roles for Boards
While popular management literature and government documents tend to idealise Board members' activities through the use of 'heroic' narratives,[16] there is considerable debate over the extent to which Boards undertake the classic instrumentalist functions of establishing objectives and core strategies. Within the empirical and critical theory literature, Boards have been characterised as performing largely non-instrumental roles by acting primarily as legitimating institutions that formally declare decisions negotiated elsewhere. [17] These perspectives indicate the potential importance of the symbolic and ceremonial value of Boards and the need to explore efficacy of Board *performances* in a

more dramaturgical sense. In this regard, Hajer [18, 19] has outlined a framework for the analysis of the performative dimension of Board governance. The approach opens up the day-to-day interactions of Board members for analysis through consideration of the *setting* in which deliberation takes place; the *scripting* in terms of the actors involved in the decision-making forum; the *staging* in terms of deliberate attempts to organise the interaction between participants by drawing on existing symbols; and the *performance* in terms of the way in which the interaction constructs new knowledge, understandings and power relationships that project forward to shape future interactions and provide opportunities for challenge and change over time. While we believe that assessments of the performative aspects of Board behaviour are likely to be important, the survey approaches used in this study largely preclude such assessments and they are not considered further.

Assessing Boards

As interest has grown in understanding the effectiveness of Boards, both inside and outside of health care, a range of Board assessment tools have been developed and applied [15, 20]. Most prominent among these, and a tool that has seen some use in health care, is the 65-item Board Self-Assessment Questionnaire (BSAQ). The BSAQ is derived from research highlighting the characteristics of effective non-profit governing Boards in the United States. [21, 22]

The initial research on BSAQ examined the practices of Boards identified by a panel of experts on Board development as either reputedly very effective or reputedly very ineffective. On the basis of this dichotomy of Board development, the researchers isolated observable behaviours that were distinctive to the more effective Boards, and using the critical incident technique as part of a qualitative study, identified six dimensions or competencies of effective Board performance. [21] Following the qualitative phase, structured interviews with Boards of trustees were used to aid the development of a self-administered 65-item questionnaire, where each item is answered using a 4-point Likert-type scale. The BSAQ has subsequently been subject to extensive testing for validity, reliability and sensitivity and this process confirmed that the six theoretically-derived dimensions also had some empirical distinctiveness. [23] These six dimensions are labelled: contextual, educational, interpersonal, analytical, political and strategic (See Box 1 for more details). Four of these dimensions relate directly to Garratt's instrumental Board tasks (located in Figure 1) and the remaining two (educational and interpersonal) are more behavioural, reflecting recognition of the need for Boards to develop group cohesion, reflection and development.

<< Box 1 about here>>

Survey methods

Given the paucity of information available on English NHS Boards, we used the BSAQ tool along with other survey instruments as a means of providing an account of Board composition, activities and orientations. Our goal was first, to provide a basic descriptive account of English NHS Boards in acute hospitals, which is currently lacking in the literature. Second, we wanted to provide a snapshot of the BSAQ six-dimensional structure applied to English NHS Boards. Finally, we sought to explore whether there

were major differences between different types of hospitals, looking at Foundation Trusts *versus* non-Foundation Trusts, and Teaching Hospitals *versus* non-Teaching Hospitals.

Two national surveys were undertaken about Board management in NHS acute and specialist hospital trusts in England. The first of these surveys was issued to 150 Trusts in the financial year 2011/12 as part of the annual Trust survey carried out by Dr Foster . The questionnaire was completed online *via* a dedicated web tool (available on request from the authors). This survey gathered data on each Trust's Board, and 145 replies were received making for an overall response rate of 97%. We believe that this response rate is unusually high because of the levels of engagement of NHS Trusts with Dr Foster (in some cases responses were omitted from individual questions making the effective response rate slightly lower for some data items).

The second survey targeted individual Board members from these Trusts. We used an adapted version of the BSAQ questionnaire that had been tested previously with a small sample of Foundation Trusts in the English NHS [24] (unpublished data; tool and report available from the authors on request). This survey was also completed through on-line means, and data were gathered between May 2012 and April 2013. By this time period, Trust numbers were reduced to 144 because of merger activity in the sector. A total of 334 responses were received from 165 executive and 169 non-executive board members, providing at least one response from 95 of the 144 NHS Trusts then in existence (66%). In order to gain Trust-based estimates on each of the six BSAQ dimensions, replies from individuals from the same Trust were aggregated.

For all of the main indicators calculated across both surveys we explored differences between Foundation Trusts and non-Foundation Trusts, and between Teaching Hospitals and non-Teaching Hospitals.

Survey findings
The findings are presented and discussed under three broad headings: (1) Board size and structure, including clinical representation on the Board; (2) Board engagement with patient safety issues, including the use of diverse sources of hard and soft information; and (3) aggregate Trust Board responses along the six dimensions that make up the BSAQ.

(1) Board size and composition

Given the range and diversity of roles required of NHS Trust Boards, it follows that they need to be of sufficient size and diversity. The smallest Board in our sample had eight members, and in general Boards were tightly clustered in size between ten and fifteen strong. Around 42% of Boards had 10-12 members and around 51% had 13-15 members, with the largest Board numbering only seventeen. We found no significant difference in Board size between Trusts of different types (Foundation / non-Foundation; Teaching / non-teaching).

In our study, around 62% of Boards had three or fewer serving Board members with clinical backgrounds. For about two-thirds of the Trusts (63%), Board members with a clinical background comprised less than 30% of the Board. We found no significant differences between Foundation and non-Foundation Trusts or teaching and non-teaching

Trusts in the distribution of Board members with clinical backgrounds. Our findings chime with recent work that focused on NEDs [8], which found that only half of Trusts (52%) had *any* NED with healthcare leadership experience, with the overwhelming majority of NEDs (86%) being drawn from a commercial, financial or managerial background (non-clinical).

(2) Board engagement with patient safety issues
In this study, Boards appear to give considerable time to safety and quality issues. Only a fifth of Trust boards (21%) reported that 30% or less of their time was spent discussing safety and quality issues. However only a quarter (26%) reported that more than 60% of their Board time was spent on these issues.

Moreover, a very high proportion of English NHS Trusts reported the kinds of desirable characteristics and Board-related processes that research says may be associated with higher performance (see Box 2). On only two of these questions (safety measures in the CEO's performance review, and formal training for Board members on quality and safety) did affirmation fall at or below 90%. There was a small (but still non-significant) difference between Foundation and non-Foundation Trusts with respect to Board members receiving formal training in relation to patient safety, with 90% of Foundation Trusts versus 83% of non-Foundation Trusts reportedly receiving training. Other differences between Trusts of different types on the raft of measures in Box 2 were minimal.

These generally high (or very high) 'desirable responses' by Trusts may represent considerable Board attention being paid to quality and safety, especially in the light of scandals such as Mid-Staffs, and/or they may reflect a growing awareness of the importance of signalling that such issues are being taken seriously.

<<Box 1 about here>>

In our national survey we found that hospital Boards were using a wide range of hard performance metrics and soft intelligence to monitor their organisation with regard to patient safety. Hard, quantitative data were reportedly used at every Board meeting across most hospital Trusts (>80%), including a range of clinical outcomes measures, infection rates and process measures such as medication errors and readmission rates. It is noteworthy however that fewer Trusts reported routine reporting of patient safety surveys (81%) and implementation of patient safety alerts (79%). A much smaller proportion of Trusts (57%) routinely report morbidity rates at every Board meeting. There was no appreciable difference between Foundation / non-Foundation and Teaching / non-Teaching Trusts on most reporting of performance metrics, except for 'formal morbidity reporting' where 52% of non-Foundation Trusts compared with 60% of Foundation Trusts routinely presented these at Board meetings.

There were some differences between Foundation and non-Foundation Trusts, and also between Teaching and non-Teaching Trusts, in their use of softer intelligence, but these differences were not marked, and nor were they consistent. For example, the difference between Foundation and non-Foundation Trusts in their use of patients stories was 8% (80% vs. 88%); the same difference seen in their use of Board members engaging with clinicians (91% vs. 83%), but with the direction of difference reversed.

<<Box 2 about here>>

(3) Using BSAQ to assess English NHS Boards
The BSAQ was developed in the US voluntary sector [21] but has seen some application in the health care arena, almost entirely in the US.[21,22] The BSAQ data gathered as part of this study showed general high or very high levels of agreement with desirable statements of practice in each of the six previously identified dimensions (see Box 1). Aggregate levels of agreement within each dimension ranged from 73% (on the interpersonal dimension) to 85% (on the political dimension). Differences between aggregate levels of agreement for Foundation Trust/not-Foundation Trust were generally small: across the six dimensions these difference between Trust types ranged from 0-4%. For Teaching hospitals/non-Teaching Hospitals the differences ranged from 1-5%. Nonetheless, there was some consistency in these data, with non-FT Boards generally scoring slightly higher than FT Boards across all six dimensions except 'strategic', and Teaching Boards generally scoring slightly higher than non-Teaching boards across all six dimensions except 'educational'. However, none of these differences were statistically significant.

Discussion and conclusions

We first examined Board size and composition. English NHS Boards are tightly clustered in size between ten and fifteen members. In theory the benefits of having a large Board, particularly in relation to an increased capacity for monitoring, may be outweighed by higher transaction costs, informational asymmetry, and communication and decision-making problems.[5] Indeed, in sectors outside health care, it has been found that there is an inverted U-shaped relationship between board size and performance [5] with a suggested optimum size of around nineteen (rather higher than the typical Board found in this study). There are similar tensions in relation to the ideal proportion of non-executive directors [26] and there is some evidence from a Dutch study that large boards in very large organisations may be value reducing, but not in smaller corporations.[27] Understanding the value and dynamics of Boards of different sizes remains to be unravelled in health care.

Size may be one crucial aspect of Boards: composition – and especially clinical representation and/or expertise – is another. Recent work [8] has drawn attention to the limited numbers of NEDs with clinical backgrounds on English NHS Boards, and our survey data show that those with clinical backgrounds are most usually heavily outnumbered across the Board as a whole. Yet attempts to involve doctors and other health care clinicians in formal management has been an explicit policy goal in the NHS since the Griffiths report of 1983, and clinical leadership development was a key recommendation of Lord Darzi's Next Stage Review. This has led to recent initiatives to promote a mixed economy of clinical and non-clinical senior managers in the NHS. It would appear that such initiatives still have some way to go.

It remains unclear what an optimal composition of a Board would look like, yet clinical involvement in the Board may be important. Work in the US suggests that clinical expertise on Boards is associated with better performance [28, 29] and more recent research in the English NHS that looked at the boards of English NHS acute trusts between 2005-06

and 2008-09 found Trusts with a high proportion of doctors on their Boards were also those that performed best in terms of healthcare quality. [9] However, this study did *not* find the same level of support for clinical professions such as nurses and other allied health professions turned directors.

In carrying out their oversight role, a key task of hospital Boards is to obtain, process and interpret information relating to performance. Indeed empirical research in the US has shown that hospital Boards that focus on the collection and analysis of performance metrics, including dashboards, scorecards and national benchmarks, tend to have better quality outcomes than those where measurement is less of a priority.[28] Our data suggest high or very high levels of agreement by Board members with a wide range of formal and informal practices (including regular review of hard and soft data sources) that might be thought to be important for quality and safety. In this we found minimal and inconsistent differences between Trusts of varying types (FT/non-FT; Teaching/non-Teaching). Whether this represents good practice in-depth or more superficial reporting of good practice remains to be properly investigated.

Finally, we explored the use of the BSAQ Board assessment tool. This again showed consistently high rates of 'desirable' responses. Previous work in the US Voluntary sector has shown a relationship between higher scores on various dimensions of the BSAQ and organisational performance. However, a small-scale unpublished study in the UK that focused on 21 Foundation Trusts [24] found no link between BSAQ scores and clinical productivity, although there were apparently some associations with financial performance. Taken together then, this application of the BSAQ in a large sample of UK hospitals, and the suggestion that BSAQ scores may be associated with organisational performance from the literature, suggest that this may be a fruitful future line of enquiry.

In sum, this study provides the best account to-date of English NHS Boards and their actions around health care quality and patient safety. It thus lays the groundwork for further empirical research exploring the dynamics, influences and impacts of Boards on important health system processes, outputs and outcomes.

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Ethics approval

The National Research Ethics Service (NRES) in a letter dated 4/11/11informed us that ethics approval was not required as the study only involved staff.

Figure 1 The main functions of hospital Boards (adapted from [4, 15])

	Short term focus on 'conformance'	**Long term focus on 'performance'**
External Focus	*Accountability* • Ensuring external accountabilities are met, e.g. to stakeholders, funders, regulators. • Meeting audit, inspection and reporting requirements	*Policy formulation* • Setting and safeguarding the organisation's mission and values • Deciding long-term goals • Ensuring appropriate policies and systems in place
Internal Focus	*Supervision* • Appointing and rewarding senior management • Overseeing management performance • Monitoring key performance indicators • Monitoring key financial and budgetary controls • Managing risks	*Strategic thinking* • Agreeing strategic direction • Shaping and agreeing long-term plans • Reviewing and deciding major resource decisions and investments

Box 1: The Six BSAQ Dimensions of Board Competencies.

1. Contextual dimension. The board understands and takes into account the culture, values and norms of the organisation it governs.

2. Educational dimension. The board takes the necessary steps to ensure that all board members are well-informed about the organisation and the professions working there as well as the board's own roles, responsibilities and performance.

3. Interpersonal dimension. The board nurtures the development of board members as a group, attends to the board's collective welfare, and fosters a sense of cohesiveness.

4. Analytical dimension. The board recognises complexities and subtleties in the issues it faces and draws upon multiple perspectives to dissect complex problems and to synthesise appropriate responses.

5. Political dimension. The board accepts as one of its primary responsibilities the need to develop and maintain healthy relationships among key stakeholders.

6. Strategic dimension. The board helps envision and shape institutional direction and helps ensure a strategic approach to the organisation's future.

Box 2: Prevalence of desirable characteristics of Boards in the English NHS

Does the board have a formal subcommittee that discusses patient safety issues? [YES: 100%]
Are there procedures for proactively responding to the reporting of staff concerns about patient safety? [YES: 100%]
Have the board set explicit measurable goals for improving performance in relation to patient safety? [YES: 98%]
Does the board have formal procedures for reporting inappropriate behaviours in relation to patient safety on a regular basis? [YES: 98%]
Have strategic goals and objectives related to patient safety been distributed to staff groups within the last 12 months? [YES: 99%]
Are patient safety measures included in the Chief Executive Officer's performance review? [YES: 90%]
Over the past year, have board members received formal training in relation to patient safety? [YES: 87%]