Towards a framework for enhancing the performance of NHS boards: a synthesis of the evidence about board governance, board effectiveness and board development

N Chambers,[1]* G Harvey,[1] R Mannion,[2] J Bond[1] and J Marshall[1]

[1]Manchester Business School, University of Manchester, Manchester, UK
[2]Health Services Management Centre, University of Birmingham, Birmingham, UK

*Corresponding author

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Scientific summary

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Background

There is a need to reduce the variation in organisational performance across the NHS (e.g. as measured by the quality and safety of care provided, and by efficiency and productivity), for which boards hold ultimate responsibility. By exploring how boards can add value we hope that this research will benefit patients and improve service efficiency and effectiveness.

We know that there are knowledge gaps in relation to the composition and characteristics of effective boards in the NHS, their impact and the range of tools and techniques available for developing effective boards. This study therefore aims to add to existing knowledge by:

1. providing a theoretical contribution to board governance and relating it to the NHS context
2. offering fresh insights into effective board composition, structures, processes and behaviours in the NHS
3. furthering an understanding of how NHS boards can affect organisational performance
4. summarising and analysing the range of board assessment tools and development interventions available for the NHS.

Objectives

- Objective 1: to explore the main strands of the literature about boards and to identify the main theoretical and conceptual frameworks.
- Objective 2: to understand to what extent the experiences of NHS boards match these theories and to provide an explanatory framework for understanding the characteristics of effective boards in the NHS.
- Objective 3: to assess the empirical evidence relating to how NHS boards can contribute to organisational performance.
- Objective 4: to map and evaluate different approaches to board development including diagnostic tools, models of assessment and facilitation.

Methods

The study adopted a realist approach to an evidence synthesis of a diffuse literature relating to boards and organisational performance, with particular reference to health-care boards and with special emphasis on the NHS. We searched the literature using and linking key terms. A search was conducted across relevant library and external sources including ABI/INFORM® (ProQuest, Ann Arbor, MI, USA), SciVerse® ScienceDirect® (Elsevier, Amsterdam, the Netherlands), MEDLINE, EMBASE and the Social Science Research Network, from 1968 to 2011. Abstracts and summaries of identified references were reviewed to test for relevance and to eliminate duplication before selecting a smaller number for closer scrutiny and sifting.

The review method was based on principles of realistic evaluation in which the focus is on reviewing complex social interventions. It seeks answers to the questions, '*What works, for whom, in what circumstances, in what respects and why?*' It engages stakeholders throughout the process. In this case we convened a joint advisory and stakeholder group to support the development of the research questions and testable propositions and to check emerging findings.

Results

Theories about boards

We explored the main theories about boards in the general literature and developed a framework for interpreting each of the theories according to different contextual circumstances.

Board practices

We explored the different frameworks that have developed from theory and from practice and categorised them into the three elements of composition (board structure), focus (what the board does) and dynamics (the behavioural dimension). We then began to explore the potential conjunction between board theories and practices; this indicates the potential consequences of the adoption of particular views about the role of the board, the composition of the board and sets of board behaviours.

Non-profit, public and health-care boards

We have concluded that the theories and frameworks for boards in general all have some relevance and utility for health-care boards. There are, however, some important distinguishing characteristics in the public, non-profit and health-care sectors, including social enterprises:

- Social performance (public value) as well as financial performance is a core purpose.
- Non-profit board members sometimes invest more of their time and are more predisposed to 'managerial work' than their for-profit counterparts.
- Public boards may suffer from 'institutional isomorphism'. This is, in general, a pressure to conform to prevailing social norms and, in this case, refers to the practice of copying governance structures, rituals and procedures from the private sector without regard for their fitness for purpose for the public sector.
- Accountabilities on public boards may be blurred as a result of the influence of political patronage and the subversion of formal authority.
- Health-care governance of individual organisations is increasingly embedded within a complex superordinate and subordinate governance network, which stretches across organisations that are interdependent in a health-care system.
- The existence of hybridised corporate and philanthropic models of governance.
- There is relatively little involvement in the setting of strategy as opposed to the endorsement of strategy.

Contingency and evolutionary theories

Many authors argue that board practices do vary according to circumstances, in both the private and the public sectors. As well as national, geographical, cultural, market, organisation size, sectoral and service differences, the following are often mentioned as key variables:

- organisation life cycle (start-up, mature, decline)
- stability compared with transformation or crisis
- degree of professionalisation.

Choosing the appropriate mechanisms (whether it be around board composition, board focus or board behaviours) to achieve the desired outcomes appears to be important according to the particular situation. For example, for stable organisations, increased monitoring and a strengthened rein on a powerful chief executive officer (CEO) if he or she has been in position for some time may be indicated (in accordance with agency theory), in contrast to a focus on boundary spanning and on the external environment (in accordance with resource dependency theory) in circumstances of turbulence and threat.

Boards and organisational performance

In this section we specifically examined associations between boards and organisational performance. In the general references (not relating to health care specifically) we found that most academic papers were focused on performance in financial terms. The findings are therefore of direct relevance but can offer only

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partial enlightenment for the non-profit and public sectors, including for social enterprises. The findings from the general literature can be summarised as follows:

- Contradictory evidence. There was evidence of positive and negative associations or no effect in terms of overall impact of governance on performance and for specific aspects of governance studied (e.g. board size, duality, gender and ethnic diversity) within statistical analyses.
- Contingent nature of relationships between key variables. In relation to gender, it generally appears that gender diversity has a positive impact on performance in firms that have otherwise weak governance, as measured by their ability to resist takeovers; however, in firms with strong governance, greater gender diversity may result in overmonitoring and reduce shareholder value. Second, in relation to the length of tenure of outside directors, outside director tenure is positively related to performance, with the accumulated learning and power effects of long tenure enabling directors to be more effective in their various governance roles; however, these benefits diminish as tenure increases. In relation to board strategy, board independence (i.e. majority of outside directors) has a significantly more positive effect on performance for firms pursuing a strategy of cost-efficiency than for those pursuing a strategy of innovation. Boards need to reflect on their own strategy in determining the level of independent input needed.
- There is some evidence to suggest that the benefits accrued by larger boards, particularly in relation to increased monitoring, are outweighed by higher agency costs, informational asymmetry and communication and decision-making problems.
- Improved monitoring can come at a cost of weaker strategic advising and greater managerial myopia. Firms with boards that monitor intensely exhibit worse acquisition performance and reduced corporate innovation.

In relation to the health-care-related literature, we found the following:

- Studies comparing corporate and philanthropic models of governance suggest that corporate models are associated with increased operational efficiency, increased market share and increased volume of adjusted admissions. Hospitals with a corporate governance configuration (i.e. smaller, narrow membership, greater management participation, strategic focus, scrutiny of the CEO, competitive positioning) were more likely to respond to major change by diversification or merger and less likely to experience closure.
- With regard to high-performing hospitals, they have a 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; boards are significantly more familiar with current performance and significantly more involved in reviewing quality data; and more time is spent on clinical quality at board meetings (greater than the time spent on financial performance).
- Board practices that are associated with better performance in processes of care and mortality include having a board quality committee, establishing strategic goals for quality improvement and having physician involvement on the board. Key mechanisms linked to these board practices are signalling a visible and steady board leadership for quality; effective organisational structures for overseeing quality; and will–execution–constancy of purpose.
- Boards of high-performing hospitals are more fully engaged in key governance processes and the prevailing governance culture is more interactive and proactive.
- Health-care governance failings in the UK and USA are associated with boards having a comparative lack of focus on clinical performance and outcomes and a preoccupation with financial matters, or indeed not being sighted on the latter. There were also organisational culture issues including lack of grip by the board either on undesirable management behaviours or on management performance.

Board development

There is some evidence that investment in board development affects organisational performance (e.g. improved board member confidence, greater board engagement and challenge, better financial results) but there is comparatively little definitive to report. We have identified four main stages in the organisational life cycle that affect choices about the focus for board development. These are start-up, growth, maturity and decline.

We are at the stage of being able to map the range of interventions and their relevance in relation to context, mechanism and (desired) outcome configurations. This is an advance on existing guidance for boards, which is generally predicated on there being one best way. There are some clues in relation to the importance of the role of an external facilitator in board development. What is not possible is to determine the effectiveness of board interventions as there are no significant studies on this, other than self-reports. There is thus a lack of any underlying empirical basis for the tools and a lack of evaluation of the impact of the interventions.

Conclusions

Understanding about boards in the NHS context

There is not a simple theory about how boards should operate. We have outlined a realist-based framework of board theories, contextual assumptions, mechanisms and intended outcomes. This suggests that the use of certain models for boards may be more appropriate than others, depending on what the priority is in terms of organisation outcome. We have identified some important distinguishing characteristics in the public and non-profit sectors, including for social enterprises. We have identified some support for the theory of high trust, high challenge and high engagement but with less empirical evidence to support the first part of this triadic framework.

Effective board composition, structures, processes and behaviours in the NHS

In the health-care sector we found evidence of the importance of appropriate organisation–environment linkages, increasing embeddedness of health-care governance as part of complex superordinate and subordinate governance networks within and across institutions, hybridised corporate and philanthropic models of governance and little involvement in the setting of strategy as opposed to the endorsement of strategy.

The following are often mentioned as key variables:

- organisation life cycle (start-up, mature, decline)
- stability compared with transformation or crisis
- degree of professionalisation.

Choosing the appropriate mechanisms (whether it be around board composition, board focus or board behaviours) to achieve the desired outcomes appears to be important according to the particular situation.

Understanding about how NHS boards can affect organisational performance

Evidence from empirical studies indicates the importance of taking into account the internal and external environment in the choices that boards make about diversity, board size, proportion of insider and outsider directors, strategic focus and the balance of time spent on advisory/partnering as distinct from monitoring functions. In addition, there was some contradictory evidence and contingent relationships between variables, indicating some demiregularities (e.g. gender diversity is advocated in some circumstances, such as the need for improved monitoring, and not in others). On the whole, the evidence lends some further support for a theoretical framework about the dynamics of an effective board in relation to challenge, trust and engagement, but modified in the light of our developing understanding about the linkages between different contexts and desired outcomes. Although a theoretical position is available on the issue of trust on boards, there is less empirical evidence to support this part of the proposed framework.

Board development tools, techniques and interventions

We identified five areas where board development approaches should be more focused. First, we found an inadequate focus on the existence of competing board theories and models. Second, in relation to the social purpose of health-care organisations, board development may not be giving primacy to developing the skills of the board in addressing clinical quality. Third, in the balance of board tasks, we did not find that

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board development frameworks drew sufficiently from the elements of fiduciary, strategic and generative governance. Fourth, there is an inadequate focus on contingency thinking. Finally, the evidence suggests that boards in some circumstances may do well to focus strongly on strategy. We could not find much evidence of an emphasis on developing the quality of strategic thinking and decision-making by boards in board development programmes.

Areas for further research

We suggest three main areas for further research:

1. We would recommend further empirical studies on the question of the composition of NHS boards, replicating some of the studies that we have analysed that have taken place outside the health-care sector. This would include questions on board size and the issue of the philanthropic compared with the corporate model, the proportion of non-executive directors (lay members) compared with managers, length of tenure, diversity and the background and expertise of non-executive directors. This would offer an evidence base for the first time around board composition for the NHS.
2. Our analysis on non-profit and health-care boards leads us to an understanding that NHS boards do have social performance (public value) as well as financial performance as a core purpose, but permission for an overarching focus on clinical quality may only just be emerging. We recommend a study to complement the mainly US studies that identifies the conditions under which this focus on clinical quality, encompassing clinical effectiveness and patient experience as well as patient safety, is allowed to flourish.
3. We could not find studies that evaluated the impact of board development tools, interventions and programmes on organisation outcomes. We therefore recommend further research that investigates associations between board development activities and organisational performance, and the role of external facilitation, mindful of the mediating effect of different health-care system contexts. This would offer an understanding for the first time of the contribution of board development to higher organisational performance.

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