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

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1. Aims/Objectives:

The aims of this proposed literature synthesis are to provide intelligence for enhanced NHS board effectiveness, to understand the strengths, weaknesses and gaps in existing theories about boards and to offer a practical guide for NHS boards for their development. The 4 objectives and research questions in more detail are:

Objective 1: To explore the main strands of the literature (for example in corporate governance, behavioural economics, organisational studies, organisational strategy, organisational psychology, public management, healthcare management) about boards and to identify the main theoretical and conceptual frameworks which relate to the structure, purpose, functions, behaviours and effectiveness of boards
Research question 1: Where are the main disciplinary sources of ideas about boards and what are the principal theories, conceptual frameworks and main paradigms?

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
Research question 2: How can theories and evidence about how boards operate in general help NHS boards in their work, in particular in the light of recent and forthcoming changes to the structure and governance arrangements in the NHS?

Objective 3: To assess the empirical evidence about how NHS boards can contribute to organisational performance
Research question 3: What is the empirical evidence (positive and negative) about the impact of NHS boards on performance, including at different stages in the performance cycle?

Objective 4: To map and evaluate different approaches to board development including diagnostic tools, models of assessment and facilitation, and identify how these approaches relate to theories about board effectiveness and to their impact on organisation performance
Research question 4: What are the different approaches to healthcare board development and which are likely to work best in different contexts and types of NHS organisations?

2. Background:

Theories about boards

Boards were developed as a result of the industrial revolution, the growing commercial complexity of business and the gradual separation of ownership from control. Boards represented the interests of absent owners or shareholders (the principals), and management became the agents of the board (Pointer, 1999). The earliest theory about boards was thus agency theory which is predicated on the notion that the shareholders' and managers' interests are likely to be different and that the behaviours of both sets of actors are characterised by self-interested opportunism (Berle and Means, 1932). Other theories developed later, and are reviewed extensively by Cornforth (2003). These include managerial hegemony (according to which the managers rather than the owners make the key decisions), stewardship theory (in which managers and owners share a common agenda and work 'side by side') and stakeholder theory, according to which board members represent the different interests of members with a stake in the organisation. Models of board behaviour can be related to these different theories: for example, agency theory, which held sway until recently, is connected to a 'challenge and compliance' set of behaviours, whereas stewardship theory relates to a high trust

partnership style of working, and in a stakeholder model, board members tend to be most vocal when articulating the interests of 'their' constituency (ibid). Related to this are theories about the sources and use of board power, including the power of the chief executive (Herman, 1981), the discretionary effort and skill exercised by non executive board members (Pettigrew and McNulty, 1995), the increased role of the board in periods of crisis or transition (Lorsch and MacIver, 1989) which can be followed by 'coasting' according to the stress/inertia theory (Jas and Skelcher, 2005).

What do boards actually do? Both agency theory and stewardship theory, (along with other theories of corporate governance) have been criticised for only illuminating particular aspects of corporate governance and board roles. As a result there have been calls for frameworks that combine the insights of different theories (Tricker, 2000, Cornforth, 2003).

One useful model that helps integrate the insights of these different theories has been put forward by Garratt (1997) drawing on an earlier model by Tricker (1980). Garratt suggests there are two main dimensions of the board's role, what he calls 'conformance' and 'performance'. *Conformance* involves two main functions: *external accountability* including compliance with legal and regulatory requirements and accountability to shareholders or other stakeholders, and *supervision of management* through oversight, monitoring performance and making sure that there are adequate internal controls. This conformance dimension matches quite closely with agency theory perspective on governance. By contrast, the *performance* dimension is about driving the organisation forward to better achieve its mission and goals. This again consists of two main functions, *policy formulation* and *strategic thinking*, to take the organisation forward. The performance dimension is in keeping with stewardship theory of corporate governance. These four main functions of boards are shown diagrammatically in figure 1. This framework suggests that boards need to be concerned with both the conformance and performance dimensions of corporate governance.

Figure 1: The main functions of boards (adapted from Garratt, 1997:45-7)

	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 agree long-term plans** • **Reviewing and deciding major resource decisions and investments.**

What do these theories have to say about the relationship between corporate governance and performance? Agency theory with its emphasis on conformance suggests that the monitoring role of the board, supported by processes such as external audit and reporting requirements, is likely to reduce problems of management pursuing their own interests or performing poorly. The emphasis is on avoiding performance problems stemming from poor management or inappropriate use of managerial discretion. Interestingly much of the recent interest in improving corporate governance in both the private and public sectors has been stimulated by high profile failures and scandals.

In contrast, stewardship theory's emphasis on 'performance' suggests the main role of boards is to improve long-term performance by the board working with management to develop appropriate policies and strategies. Hence, rather than avoiding poor performance or managerial failures the emphasis is on improving future

Despite their different emphases, both theories assume that non-executive board members are able to exercise influence over senior management, and that it is through this influence on management that they are able to bring about change and influence organisational performance. However, other corporate governance theories, which focus on the relative power of non-executive board members with respect to management, as seen earlier, seriously question whether boards are able to exert significant influence on management.

Evidence about NHS boards and performance

Although there are resonances, the extent to which these generic theories about boards are applicable in the UK healthcare sector is not yet well understood. Equally, although boards in the English NHS are derived in structure and function from the Anglo-Saxon private sector unitary board model which predominates in UK and US business (Ferlie et al, 1996, Garratt, 1997), it is not clear whether this structure fits the purpose or how or why it was arrived at. Indeed within the four home countries of the UK itself, with the advent of devolution, there have been deepening policy differences (for example in the role of the market) which have been accompanied by an increasing divergence in governance arrangements. The Welsh board model is stakeholder-based with up to 25 members on each board, resembling the English NHS pre-1990. Scotland has an integrated health model and a unified board structure with strong local authority representation and is experimenting with democratic elections on to boards. Carver however postulates that key governance principles can work with whatever structural arrangements have come about as a result of a board's composition, history, and particular circumstances (Carver, 2001) but the extent to which different governance arrangements are associated with organisation performance in the healthcare sector has not been extensively mapped although the importance of local context has been noted (Eeckloo et al, 2007) and useful work has been carried out at the system level (Davies, 2005).

In a recent literature review on board effectiveness for the NHS Institute, Selim and colleagues concluded that there was no one best way to achieve an effective board, as general principles had to be applied to the circumstances, strategic focus and stage of development of the particular organisation. A series of general principles did emerge from this review, including a focus on the 'right' structure, people, culture, tasks, information, processes and follow-through, but the case for the extent to which these are applicable to the NHS was not made (Selim et al, 2009).

The evidence about relationships between organisational cultures and performance in the NHS is emerging: it is becoming clearer that culture does matter and that certain cultural characteristics are associated with better performance in some domains (Mannion, 2010). There are some clues from a selective literature review about what boards in the wider UK public sector might do well to pay attention to (Chambers and Cornforth, 2010). There is, for example, evidence that smaller boards with well functioning sub committees are associated with better performance. A board focus on the three areas of strategy, use of resources and talent management appears important. Board dynamics is emerging as a significant element, with a triadic proposition of working relationships which combine the three elements of (1) high trust between board colleagues, (2) high challenge by non-executives to executive proposals, and (3) high levels of engagement in and out of board meetings (ibid). The energy and expertise of non executive directors is argued to be important in partnering with managers to shape strategy and in tracking performance (ibid). Although prescribed as important, there is little evidence however to link positive chair and chief executive relationships (the '2 at the top') with board or organisational performance (Office for Public Management, 2009) although some (weak) evidence from within the NHS (Exworthy and Robinson, 2001) as well as outside (Kakabadse, 2006) indicating that poor relationships between these two can negatively affect board and organisational performance. A recently published report on new governance arrangements in the NHS (Storey et al, 2010) suggests that aspects of organisation performance, particularly the use of resources, might be associated with some aspects of board working, in particular the contribution of clinicians, the presence of highly influential non executive directors and chief executives who exert moderate to high control but do not behave autocratically. The impact of board members on the quality of services is more difficult to detect (ibid)
There is increasing evidence available about the conditions under which NHS boards preside over organisation failures. Inquiries and reviews have repeatedly pointed to a lack of challenge by the board at critical junctures. In the case of the financial meltdown at North Bristol NHS Trust in 2003, Deloitte and Touche reflect on relationship difficulties at board level and a failure to probe the financial situation and to put in place risk management processes (Avon, Gloucestershire and Wiltshire SHA, 2003). The Francis Report (2010) into

the failings at mid Staffordshire NHS Foundation Trust found that the board lacked focus on the job of a hospital, had poor insight and a confused system of governance.

There is indeed no shortage of steer for NHS boards. A recent study of the chair / chief executive relationship, which confirms and updates findings from earlier work on 'two at the top' (Exworthy and Robinson, 2001) summarised the literature in general as being dominated by prescription rather than insight (OPM, 2009). The NHS Confederation has identified four key characteristics of effective boards: a focus on strategic decision-making, trust and corporate working, constructive challenge and effective chairs. In their examination of boards at work, however, the authors found that 'the daily grind' often obscured strategic decision-making and, whilst there was often a good deal of trust between board members, there was too little constructive challenge, and therefore some missed opportunities (NHS Confederation, 2005). NHS boards are expected to operate along all four of Garratt's quadrants from developing a clear vision, to clarifying strategic direction, and also to monitoring performance and accounting to local communities and to government (1997). The key challenges for NHS boards can therefore be segmented into these four quadrants and guidance reinforces this. The Healthy NHS Board (2010) published by the National Leadership Council for example focuses on three main roles of the board: formulating strategy, shaping culture and ensuring accountability with the three building blocks of context, intelligence and engagement. It also emphasizes health system governance across organizations (ibid).Over recent years there has been a particular focus on the role of the non executive director. The Higgs report (2003) into this role within the UK commercial sector called for greater clarity around responsibilities, induction, development and performance and a recent study has pointed to an association between non executive director involvement and organisation performance (Storey, 2010).

Board development

Cornforth suggests that reflexivity compensates for the impossibility of achieving an 'ideal' board structure or generic 'rules' for board effectiveness, and defines reflexivity as the process of achieving a better understanding of behaviours, roles, teamworking and impact of the board (Cornforth, 2003). West proposes that reflexivity provides the space to promote team health, creativity and robust challenge to the existing ways of doing things that is essential for innovation (West, 1997). Boards sometimes seek external support to help them in this task and may also embark on a wide-ranging organisation development programme of which development of the board is only a part.

Patching offers a 2 by 2 grid to understand the range of different interventions for effective organisation development (Patching, 1999). His argument is that the choice of interventions should depend on what the organisation's main concerns are around organisation development (OD). One half of the grid comprises achieving success through alignment (divided into OD activities for enhancing specific and generic capabilities, for example by implementing an agreed organisation-specific strategy, or embedding industry-wide best practice). The other half of the grid comprises success through change (divided into OD activities which are transformational and exploratory, for example developing a new vision or testing new ideas and challenging the status quo).

Cockman, meanwhile, describes 4 distinct consulting styles or facilitator modes (Cockman, 1999). The acceptant mode involves listening actively, encouraging 'story telling' and is particularly helpful in revealing the impact of emotions in shaping organisational life. The catalytic mode comprises collecting, shaping and rearranging information, for example through forcefield analysis, multi-voting, flowcharts, staff/customer interviews and surveys and is essential in helping the client to take decisions and move forward. In the confrontational mode the consultant highlights discrepancies for example in behaviours, decisions, espoused values and offers both challenge and support. Finally, the prescriptive mode involves the provision of expert advice and depends on the consultant's technical or content expertise in the client's area, for example his/her knowledge of comparable organisations.

Using Patching and Cockman's frameworks together with Garrett's board tasks model (see Fig 1 above) it is possible to construct a framework for board development which has a degree of relevance for all boards and in different kinds of health systems. An exploratory study to determine the utility of this for NHS boards revealed that, with refinements related to levels of maturity, espousal and practice of values and intelligent commissioning of facilitation, the model had both resonance and relevance (Chambers and Higgins, 2005).

Since then, there has been much board development activity, some of it led by the NHS Institute for Innovation

and Improvement, and some by management consultancies, but no research into the scope and effectiveness of different tools for board diagnostics, assessment and development. Outside the NHS, some studies of board development support the contention that board development is worthwhile. Brown (2007) for example, in a large study of credit unions, found that board development practices do lead to more capable board members and the presence of these board members tends to explain board performance. Holland and Jackson (1998) in a smaller matched comparison study in the non profit sector found that board development was associated with significant improvements in board performance in the experimental group in comparison with the control group. An attempt to uncover what works in board development would therefore appear to be worthwhile.

3. Need:

There is a need for reducing the variation in organisation performance across the NHS (for example, as measured by the quality and safety of care provided and efficiency and productivity) for which boards hold ultimate responsibility. By exploring how effective boards can add value here, this research will benefit patients and improve service efficiency. In the wake of the publication of the Francis Report (2010) into the failings at Mid Staffordshire NHS Foundation Trust, the chief executive of the NHS has emphasised the role of boards as guardians of patient safety. The NHS Confederation, which represents the NHS board member community, has expressed the need for more detailed analysis of the complex issues around the cultures and characteristics of boards (NHS Confederation, 2005).

Interest in how boards can control and influence organisations as complex as those that make up the NHS is likely to continue and indeed to be increased, particularly in the light of recent failings in patient safety and in view of the quality, innovation, productivity and performance (QUIPP) agenda, and as the scale of efficiencies required begins to bite.

With the advent of sweeping NHS reforms in the years up to 2012, David Nicholson has also reiterated the contribution of boards to provide the necessary challenge and support. The findings of this evidence synthesis will also be highly relevant as GP commissioning consortia begin to determine their own governance arrangements. The findings will also be timely as discussions and decisions about different forms of integrated boards take place, for example with regard to the proposed local health and well being boards and the strengthening of the 'local democratic legitimacy' of the NHS as envisaged by the White Paper, Equity and Excellence: Liberating the NHS (Department of Health, 2010).

Findings from this study will affect healthcare management practice through highlighting the contributions that boards can make. The study will use and build on a developing body of knowledge in relation to healthcare governance, organisational culture and performance which have been subjects of other funded SDO studies (for example, Sheaff, 2004, Davies, 2005, Mannion, 2010)

4. Methods:

The study is an evidence synthesis of a diffuse literature in relation to boards and organisation performance with particular reference to healthcare boards and with special emphasis on the NHS. A literature review commissioned for the NHS Institute on board effectiveness concluded that '….there is no agreement among researchers on the best framework for identifying, measuring and discussing characteristics of effective boards…..There has been a lack of clear definition of concepts and a reliance on incomplete research models. This means that there is little convergence on terminology, definitions and findings' (Selim et al, 2009:5). The terrain is characterised by some complexity in terms of the multiple locations of the evidence across different disciplinary traditions, by weakness and ambiguity in terms of association and causation (and direction of causation) and by the influence of contextual factors on board characteristics, performance and effectiveness. Given this complexity, a conventional systematic review, with its emphasis on a hierarchy of evidence and randomised controlled trials as the research design of choice to address questions of effectiveness, would not be appropriate. Indeed, a traditional systematic literature review would almost certainly be unable to take account of the multiple and inter-connected variables that influence boards and their performance.

A realist angle on the other hand emphasises the contingent nature of the evidence and addresses questions about what works in which settings, for whom, in what circumstances and why (Pawson et al, 2005). Given that board room practices have been described as a 'black box' (Selim et al, 2009), this seems a sensible approach to take: the study will aim to open that 'black box'. A realist synthesis also emphasises an iterative

approach between programme theory and predicted theory (ibid) and we therefore propose this for our over-arching research design.

Realist synthesis belongs to the family of theory driven review. It starts with knowledge and theory and ends with more refined knowledge and theory, along the way 'stalking and sifting' ideas and empirical evidence (Pawson et al, 2005). In our case, the synthesis will address questions in particular about how boards operate, in what circumstances, and why, the influence that boards have on organisational performance, and the effectiveness of tools and techniques for board development. The focus is therefore very much on mechanisms rather than on boards *per se.* Realist review learns from, rather than controls for, real world phenomena, thereby providing an acknowledgement, for our study, that no two boards are the same in human composition, context or stage of development. The limitation of realist synthesis is that it is a method which is still in development with a relatively small number of studies under its belt (Pawson 2006). However, from the reviews and literature published to date, it is an approach that appears to address the limitations of more traditional systematic review methods when dealing with complex social interventions across different circumstances, and using a range of mechanisms and with varying underlying beliefs and assumptions (Greenhalgh et al, 2007). Its focus is on offering explanations rather than judgements, and developing principles and guidance rather than making rules. For the purposes of this review, we believe this is a more appropriate course of action to take - it will offer insights for practitioners to take note of and make use of and will offer a valuable addition to the armamentarium currently available to members of NHS boards.

In considering alternative approaches, we are mindful of an analysis of alternative approaches to systematic review (see table 1 below) which underlines that only realist synthesis meets the criteria for focusing on mechanisms rather than whole programmes. In our case, this will allow us to look at discrete aspects of boards (composition, methods of working, governance arrangements and so on) rather than having to consider 'the board' as the overall unit of analysis

Table 1 : Summary of alternative approaches to systematic review

Approach	Unit of analysis	Focus of observation	End product	Application
Meta-analysis	Programme	Effect sizes	Relative power of like programmes	Whole-programme application
Narrative review	Programme	Holistic comparisons	Recipes for successful programmes	Whole or majority replication
Realist synthesis	Mechanisms	Mixed fortunes of programmes in different settings	Theory to determine best application	Mindful employment of appropriate mechanisms

From: Popay J ed (2006) Moving beyond effectiveness in evidence synthesis: methodological issues in the synthesis of diverse sources of evidence NICE, London p89

An example of the successful use of a realist synthesis was in relation to the public disclosure of healthcare information about performance. One of the outputs of this research was a theory map which exposed differences between programme theories and theories in use, which is a key aim of this proposed study: the illumination of differences between how boards 'ought 'to be working and current board practices. One of the members of this research team (GH) contributed to that work and also to the authorship of a seminal article on the topic (Pawson et al, 2005). To illustrate how theory mapping would work in this study, there is some evidence (and exhortation in current guidance) for a triadic proposition (a programme theory) that a combined culture of high trust, high challenge and high engagement by non executive directors on boards is associated with better organisation performance (Chambers and Cornforth, 2010). There is also evidence of some of the

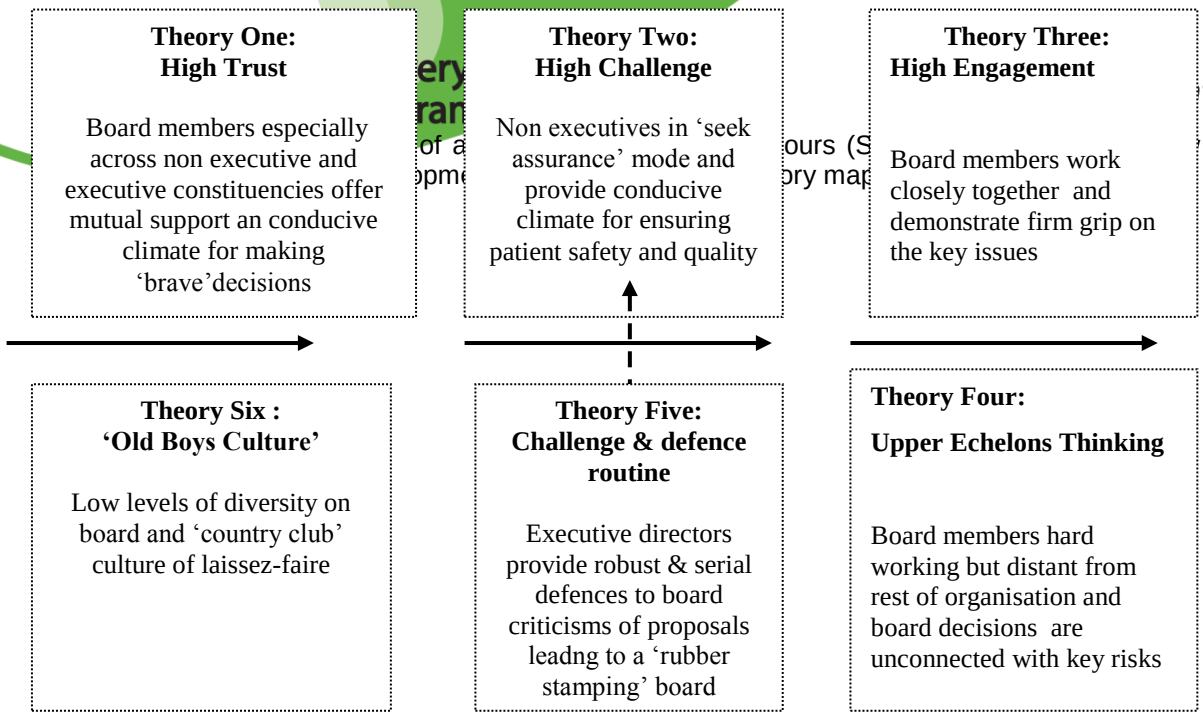


Figure 2 : An initial 'theory map' of board dynamics

One of the principles of realist synthesis is the importance of sense making. The meta-narrative mapping approach to synthesising evidence is attractive because it acknowledges different disciplinary traditions and changes to dominant narratives over time (Greenhalgh, 2004). This approach was deployed to illuminate changing paradigms across different disciplines in understanding about the diffusion of innovations (ibid). Board governance is also a good example of where the dominant narrative has changed, with a shift away from the discourse of agency theory within the political science discipline to a more hybridised one in which, inter alia, board dynamics within the organisational behaviour discipline is now playing a significant contribution. We therefore propose using a meta-narrative mapping exercise within a realist framework specifically to address our first research question which is to identify and explain the rise and fall of dominant theories about the role and functioning of boards.

A key test for SDO funded studies is that the research questions and subsequent research findings are relevant and usable for the target audience who are responsible for the organisation and delivery of healthcare. In accordance also with realist review principles, we would therefore suggest that the research questions are provisional, as we would plan to hone and refine these with a joint expert advisory and stakeholder group formed of researchers active in the relevant discipline areas, together with the target audience of board members and managers. We would plan to convene this group once on a face-to-face basis in Manchester and to run a facilitated workshop early on in the study to elicit programme theories about board structures, processes, dynamics, development and impact on organisation performance and to guide the development of the research questions. Contact would be maintained electronically during the study with members of the stakeholder group and in particular the provisional findings would be checked out with them. This embeds the 'linkage' between practitioners and researcher communities which is advocated as a key characteristic of realist synthesis and helps to move findings from research into practice (Lomas, 2000). We would like to emphasise that the interaction with NHS board members and others in the advisory group is part of the synthesis process and in order to improve the process of sense-making and interpretation of the literature that we are reviewing and will not involve any empirical data collection

We would anticipate that, in addition to the academics, stakeholder group members would include at least one 'ordinary' non executive director and one Foundation Trust governor, one board chair, one chief executive, one executive director, one opinion leader with a national-level interest and role in board development, a contact each from the NHS Confederation, Monitor, the Foundation Trust Network, the NHS Appointments Commission and from the board development team at the NHS Institute for Innovation and Improvement.

In terms of the detailed plan, it is summarised in table 2, with more detail about the search strategy provided in table 3 as this lies at the heart of the study. It is important to note that the four objectives with their associated research questions are closely inter-related. For example arriving at an understanding about different approaches to board development (the final objective) will be founded on literature on theories about boards, their application in NHS contexts, and evidence about how boards affect organisation performance. Equally, although table 2 suggests a sequential set of phases, in realist review, there is an iteration between the phases, so for example it is likely that theories about boards and explanations about the characteristics of effective boards in NHS contexts will be shaped and reshaped throughout the course of the study.

It is important to cover the territory comprehensively. This involves examination of board theory and practices in the corporate and non profit as well as government sectors, and across academic disciplines (for example corporate governance, public management, leadership, institutional economics) using expected search terms such as 'board governance' and 'board development' but also 'organisation strategy' and 'organisation performance' as well as snowballing techniques. Databases that will be searched include ABI-Inform, Business Source Premier, Medline, Embase and HMIC. In addition to building on previous relevant SDO studies (for example, Sheaff, 2004, Davies, 2005, Mannion, 2010), we understand that a research proposal (principal investigator : Russell Mannion) on the effective board governance of safe care: an investigation into the relationship between Trust Board practice and patient safety in NHS Hospital Trusts has been recommended for funding subject to satisfactory responses to comments (NIHR SDO Call 10/1007 – Patient Safety in Healthcare Organisations) and we will ensure that there are synergies between the two studies with the sharing of papers and so on

.In relation to managing the potential volume of papers, from diverse sources, the purposive sampling strategy will set strict boundaries in relation to relevance, allowing for iteration. Data extraction, and inclusion/exclusion is less linear than in traditional systematic reviews and decisions here will call for pre-existing knowledge of the subject area and the exercise of judgement on what to include/exclude from the review (drawing on advice from the research team and stakeholder group as required).

Table 2: Plan of investigation in accordance with realist synthesis and meta-narrative mapping

Phase	Actions
Define the scope of the review RQ1 Theories about boards RQ2 Experiences of NHS boards RQ3 Impact of boards on performance RQ4 Board development	• Explore literature across different disciplines and clarify questions with stakeholder/advisory group • Find and articulate the programme theories • Select 'landmark' studies • Identify main research traditions associated with board governance • Develop theory maps
Search for, extract and appraise the evidence (see also table 3 below)	• Decide purposive sampling strategy • Define search sources, terms and methods • Develop data extraction forms • Set thresholds for relevance and saturation • Test for relevance and rigour
Synthesise findings	• Compare and contrast findings from different studies • Seek confirmatory and contradictory findings • Final search in light of emerging findings • Refine theory maps and programme theories in the light of evidence
Draw conclusions and make recommendations in relation to the original	• Consult stakeholder group members in a review of findings

objectives of the study Obj 1 Explanation of theoretical and conceptual frameworks about boards Obj 2 Application of frameworks to understand characteristics of effective boards in NHS contexts Obj 3 Assessment of the evidence of how boards affect organisation performance Obj 4 Evaluation of approaches to board assessment and development	• Further refinement of findings • Disseminate review conclusions couched in theoretical terms and also in the form of a practical guide for NHS boards

Table 3: Search and extraction strategy

Decide purposive sampling strategy	• Scope the range of material to be retrieved to test particular theories and to answer specific questions • Repeat as necessary as theoretical understanding develops
Define search sources, terms and methods	• Sources to include 'grey' literature as well as research literature • Terms to be decided which will elicit theory and evidence and answer questions important to stakeholders • Methods will include data base searching, snowballing, citation tracking, hand searching • 'key word' searching of databases including ABI-Inform, Business Source Premier, Medline, Embase, HMIC
Develop data extraction forms	• Title of paper • Name of reviewer • Paradigm (theoretical lens eg classical economic theory) • Type of paper (ie research design) • Mechanisms as units of analysis: Eg board composition, methods of working, dynamics, board assessments, board assessments, board development • Findings • Importance for our research question • Methodological strength of paper in its domain
Test for relevance and rigour	• Does the paper make an original and scholarly contribution to research? • Is the paper about the topic under scrutiny? • Does it add value for NHS board members?
Set thresholds for saturation	• Check whether additional searching will add new knowledge (within limits of available time and resources)

5. Contribution to collective research effort and research utilisation:

The first knowledge product will be the main evidence synthesis report for NIHR SDO which will provide intelligence for enhanced NHS board effectiveness, founded on an analysis of the strengths, weaknesses and gaps in existing theories about boards, and on insights into the particular contexts, mechanisms and outcomes that can be identified in relation to the potential for high performing boards in the NHS. The second main knowledge product will be a practical guide for NHS boards for their development. The third will be a seminar in London arranged by the applicant researchers for members of NHS boards to present, discuss, debate and disseminate the findings and to promote the distribution and use of the guide. This seminar will provide an opportunity for participants to relate the study findings to their own circumstances and contexts. A further knowledge product will be presentation at two conferences (one academic and one practitioner) for wider dissemination of the theoretical and practical findings of the study. It is suggested that the suitable practitioner conference would be the NHS Confederation as that is the prime conference for NHS board members (CEOs,

chairs, executive and non-executive directors). It is suggested that the suitable academic conference would be at the European Health Management Association which provides a 'meeting point' for researchers, teachers, managers and policy makers with an interest in healthcare. It is also anticipated that the outcomes of the study will be submitted for publication in at least one high ranked peer reviewed academic journal (for example the British Journal of Management) as well as in a practitioner journal (for example the Health Service Journal).

6. Plan of Investigation:

The monthly project timetable is provided in table 5 below.

Table 5 Outline project timetable

Months

Month One = July 2011

Activity	**7/11**	**8/11**	**9/11**	**10/11**	**11/11**	**12/11**	**01/12**	**02/12**	**03/12**	**04/12**	**05/12**	**06/12**	**07/12**
Delineate and reconfirm scope of the review	x	x							x	x			
Contact stakeholder/advisory group	x								x	x			
Convene stakeholder/advisory group workshop				x									
Exploratory trawl of literatures	x	x	x										
Search, extract and appraise evidence (purposive sampling)			x	x	x	x	x	x	x				
Synthesise findings						x	x	x	x				
Draw conclusions										x	x		
Make recommendations including a practical guide											x	x	
Progress report to SDO							x						
Dissemination seminar												x	
Final report to SDO													x

7. Service users/public involvement:

As this is an evidence synthesis, the requirement for public involvement is not as central as it would be for an empirical study. Given the realist synthesis that we have chosen however we have emphasised the need for linkage with practitioners as well as with researchers acting as critical friends. The plan is therefore for the expert advisory and stakeholder group to include individuals from the 'ordinary' non executive community.

We would plan to convene this group once on a face-to-face basis in Manchester and to run a facilitated workshop early on in the study to elicit programme theories about board structures, processes, dynamics, development and impact on organisation performance and to guide the development of the research questions. Contact would be maintained electronically during the study with members of the stakeholder group and in particular the provisional findings would be checked out with them. This embeds the 'linkage' between practitioners and researcher communities which is advocated as a key characteristic of realist synthesis and helps to move findings from research into practice (Lomas, 2000). We would like to emphasise that the interaction with NHS board members and others in the advisory group is part of the synthesis process and in order to improve the process of sense-making and interpretation of the literature that we are reviewing and will not involve any empirical data collection

We would anticipate that, in addition to the academics, stakeholder group members would include at least one 'ordinary' non executive director and one Foundation Trust governor, one board chair, one chief executive, one executive director, one opinion leader with a national-level interest and role in board development, a contact each from the NHS Confederation, Monitor, the Foundation Trust Network, the NHS Appointments Commission and from the board development team at the NHS Institute for Innovation and Improvement.

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