NATIONAL LEADERSHIP COUNCIL
BOARD DEVELOPMENT

The Healthy NHS Board

A review of guidance and research evidence

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1 Introduction

This review has been commissioned by the National Leadership Council as a component of *The Healthy NHS Board: principles for good governance*, which aims to refresh the guiding principles presented in *Governing the NHS* (1).

Since *Governing the NHS* (1) was published in 2003, much information on the contributions Boards and their members make to the effective running of organisations has become available. This has taken the form of guidance and research evidence, both within and beyond the healthcare domain. In addition, a major review of the NHS has been carried out (2), and the NHS Constitution and an accompanying Statement of NHS Accountability have been established (3, 4). The Constitution describes the principles and values of the NHS, as well as the rights and responsibilities of patients and staff, and will stand until its planned renewal in 2018. These documents establish the key role played by Boards in ensuring these values are embedded throughout NHS organisations. It is important, then, that Boards are supported in responding to these developing challenges.

Our brief was to review how Boards contribute to the organisations they lead, using a synthesis of research evidence and guidance on best practice. Much of the structure of this work has been derived from our literature searches (see Section 2); additional guidance on key topics was provided by the Leadership Council sponsors.

This review will address:

- the concept of governance, presenting relevant models and approaches to governance, building to an overall definition of the term;
- the role of NHS Boards, presenting examples of how these roles support NHS organisations in delivering on key priorities, such as patient safety and value for money;
- the role of specific NHS Board member roles;
- the role of Board Committees;
- the "building blocks of governance," outlining how Boards use context, intelligence and engagement to guide effective governance; and
- features of effective Boards, including appropriate structure, composition and processes.

We close with a brief discussion section, which presents the overall lessons drawn from the evidence base; summarises the current relationship between guidance and research evidence; and considers how this relationship might develop further in the coming years.

2 Literature review method

Broadly, this review draws on three types of literature.

The first is literature discussing the conceptual issues underpinning 'governance', and different models of governance. This provides a framework with which the learning presented in guidance and research might be organised.

The second is guidance that has been developed on 'good governance,' aimed either directly at the NHS or at other sectors. Much of the guidance from the private sector has developed in response to various failures (5), such as the Maxwell pensions and Bank of Credit and Commerce International (BCCI) scandals (6), Enron (7) and the 2008/09 financial crisis (8). In the main, these documents have been based on consultation exercises. Some of the original guidance for the NHS has drawn on this material (1, 9, 10), while other guidance has been based on experience of failures within the NHS and the lessons for boards (11-15).

Thirdly, the review incorporates findings from empirical research, particularly those drawn from reviews of such work. To identify empirical research, the review team accessed the following research databases: PsychInfo, Medline, the Health Management Information Consortium, ScienceDirect, Emerald Management Xtra and Management and Organization Studies (SAGE). Searches were also carried out using Google Scholar.

The following search terms were used, separately and in combination: *board effectiveness*; *risk management*; *corporate governance*; *governance*; *risk*; *innovation*; *service quality*; *patient safety*; and *productivity*.

There was some duplication in the results of these searches. The review team examined abstracts to establish the relevance of the literature obtained.

In addition, experts in the field – academics, NHS board members and sponsors of this project who were interviewed as part of this project – were invited to identify research and guidance documents that they felt were significant to this work. Reference lists of the articles selected were examined to identify further relevant literature. In total, 144 references are included in this review.

It should be noted that the evidence base for connections between organisational factors, such as Board involvement, and outcomes, for example quality and safety, is weak. Variables are poorly operationalised and methods described in insufficient detail (16); and there exists a publishing bias in favour of 'success stories' (16-19). There are examples of research where associations have been found between variables, for example, the presence of a Quality Committee and lower mortality levels (21), however, these associations should be treated with caution, given the complex inter-relationships between organisational factors. The focus of future research on

Board effectiveness would be better focussing on understanding the processes and relationships between different factors.

3 What is Governance?

Both research and guidance have noted that ‘governance’ is a term that has been defined in numerous ways (1, 20). Examples include, ‘The systems and processes by which health bodies lead, direct and control their functions in order to achieve organisational objectives and by which they relate to their partners and the wider community’ (1) and, building on this definition, the ‘Systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations’ (9). The function of governance has been described as ‘to ensure that an organisation fulfils its overall purpose, achieves its intended outcomes for citizens and users and operates in an effective, efficient and ethical manner’ (21); while another definition of governance focuses more on the relationship between Boards and the rest of the organisation, stating, ‘In the public-sector or non-profit contexts, governance often refers to the relationship between an elected or designated board and the management of an organization’ (20).

As ‘governance’ has tended to be a catch-all term (22), it is important that this document sets out what we mean by the term ‘governance’ here, as well as what it does not include.

This section begins by summarising an analysis of three models of governance: agency, stakeholder and stewardship (20). We then present three approaches to governance that are of interest: *generative governance, policy governance* and *integrated governance*. Finally, this section draws out key underlying themes in the presented models, with the aim of providing a working definition of governance.

3.1 Models of governance

As an aid to analysing approaches taken to governing organisations, Denis et al (18) present three models of governance in terms of their philosophies and how these influence leadership style and its relationship with stakeholders. The authors propose their own preliminary governance framework, setting out what they view as the key functions of governance; this is summarised in Section 3.3.

3.1.1 The agency model

The agency model is hierarchical, with a focus on the ‘principal-agent relationship’ and leadership’s efforts to ensure others act appropriately on its behalf (20). It suggests that governance reflects leadership’s struggle to ensure that delegated roles – such as meeting organisational objectives – are carried out suitably. Central to this model is establishing effective monitoring

and control systems, which incorporate meaningful performance measures, incentives and sanctions.

The role of leadership in this model is described as authoritarian and individualistic: setting direction and being assured that the organisation follows.

3.1.2 The stakeholder model

The stakeholder model suggests that organisations are made up of multiple cooperative and competitive interests – the challenge is to be aware of and responsive to these interests (20). It is argued that relevant interests are not just those of shareholders, but those of 'stakeholders'; and organisational success depends on its relationship with these actors.

The aim of governance is to integrate stakeholder interests, thus keeping every stakeholder group involved, supportive and 'minimally content'; and ensure that stakeholder interests are maximised over time, by maintaining a balance between the various stakeholder interests. The model suggests such balance is best supported by building strong links with critical stakeholders; and that it will lead to organisational stability, growth and profitability.

Leadership's role is that of the skilled politician: identifying the organisation's stakeholders and negotiating with them the organisation's purpose and approach; and thus keeping these stakeholders 'on board'.

3.1.3 The stewardship model

The stewardship model is the most 'democratic' and dynamic model of the three discussed, in that it recognises a strong link between public bodies and civil society (20). It argues that the organisation thrives on shared values: employees benefit from helping the organisation achieve its goals and thus strive to support this. Therefore, a suitably skilled and autonomous workforce and actively involved stakeholders represent the best route to a successful, continuously improving organisation.

Following from this, leadership in this model is defined as collective: goals are established through inclusive debate, with the aim of creating shared responsibility and cooperation across the organisation and its stakeholders.

3.2 Approaches to governance

This section presents three approaches to governance identified in the literature and in NHS policy. Each one possesses features that might be analysed using the frameworks outlined above; and each presents an approach to governance that might be of benefit to healthcare organisations.

3.2.1 Generative governance

A review of research on Boards' role in quality and patient safety suggests that boards might benefit from adapting their established role. It questions whether it is apt to retain the established governance-management divide so

strictly, when evidence indicates that an understanding of the experiences of management and users benefits leadership and the organisation in several ways (23).

The theory behind this approach, termed 'governance as leadership', is that Boards will perform better if their work has greater influence and consequence. By engaging more closely with management, staff and the service user experience, and discussing this learning in a constructive, challenging fashion, strategy will be better informed and Board members better engaged (24). This model is quite demanding of Board members, however, recognising that they must be sufficiently knowledgeable and experienced to allow such meaningful and creative engagement to occur. Consequently, such an approach places an emphasis on Board members' skills development, especially in terms of patient safety and service quality (Sections 4.4.1 and 8.5).

3.2.2 Policy governance

The Policy Governance approach is based on clear delegation of roles and responsibilities, with a philosophy of 'controlling all it must, rather than all it can' (25). Boards act as 'owner representatives', the link between 'owners – whether legal or moral in nature' (in the case of public services, the local community) and 'operators' (the people who deliver the service).

Policy governance refers to the desired impact of the organisation as 'ends'. Examples of these might be a healthier community, or more self-sufficient patients; 'ends' never relate to the organisation performance – for example financial performance or staff retention. Such measures are classified as 'means'.

Responsibility for running the organisation and achieving organisational 'ends' is delegated fully by Boards to management, via a point of contact such as the CEO. Boards do not focus on how objectives are to be achieved; this is left instead to the creativity and innovation of management and staff. A framework of policies frees staff to select the most effective means of achieving organisational objectives – within the limits of ethics and prudence. In setting out 'ends' and these limiting policies, Boards are urged to obtain 'wisdom' from all available sources, including public, patient, staff and academic perspectives.

A review of Board contributions to quality suggests that the policy governance model can limit the focus on quality at board level, because of a failure to engage in the patient experience driven by concerns of breaching the governance-management divide (23). However, this perceived weakness may be partial: patient experience and outcomes are likely ends in any healthcare organisation; and the model entrusts healthcare professionals to identify the means by which such ends is to be achieved, which may support locally-responsive and high quality services (23, 26). Even allowing for this, though, Policy Governance appears to under-emphasise the potential benefits offered by providing visible leadership and direct engagement, which is recognised in

guidance and research as valuable (for example see Sections 4.3, 4.4 and 7.3).

3.2.3 Integrated governance

NHS guidance makes the case for bringing together corporate, financial and clinical governance – which have developed separately – to reflect 'their vital importance and the inter-dependence and inter-connection between them': essentially, placing clinical governance at the same level of priority as these other core accountability issues (9, 27).

This shift reflects the approach in private sector guidance, where there is a longstanding appreciation of the value of integrating key measures, including financial and operational performance, compliance with legal requirements and protection of organisational assets (6, 28). A review of the literature presents research suggesting such integration is appropriate in the healthcare setting (23).

3.3 Towards a definition of governance

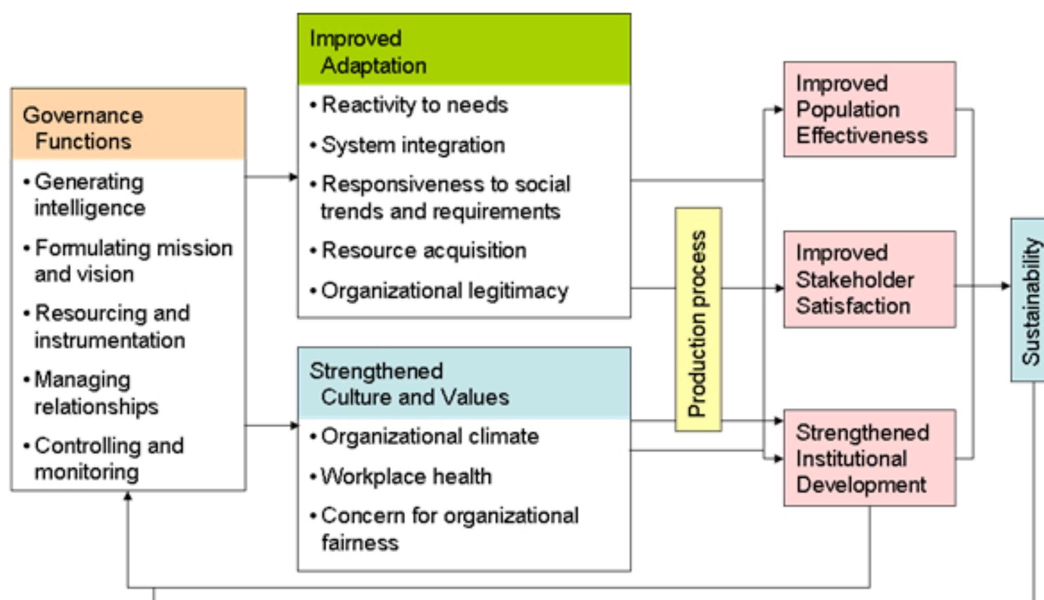
As mentioned above, there are many definitions of 'governance'. Here, we discuss two themes underlying the models and approaches outlined above; and we present two models that attempt to capture the underlying roles and functions of governance.

A theme central to all models, in various ways, is accountability. Governance involves being assured that the means are in place to hold the organisation to account (for example through monitoring and control systems) and being assured that the organisation is accountable to the outside world (for example to regulators and to the public).

Guidance emphasises the importance of drawing a distinction between 'governance' of an organisation, and its management. Governance, as outlined above, focuses on establishing strategies and systems by which Boards are assured that organisational objectives are being met. Management is the 'hands on' component of an organisation, focusing on effective implementation of the systems set in place (6, 25, 29, 30). As mentioned in Section 3.2.1, it may be that Boards will be better informed, more engaged and better enthused by their role, and indeed govern better, should they consider greater input from patients, staff and management.

Following their review of the three main models of governance, Denis et al (18) propose a framework for analysing governance (Figure 1).

Figure 1. Denis et al's proposed governance framework (20)



The authors propose that governance has five functions:

generating intelligence (knowledge that supports design and implementation of organisational goals);

formulating mission and vision (agreeing organisational purpose);

resourcing and instrumentation (creating the 'instruments' of governance, such as policies, incentives and systems of control);

managing relationships (with 'critical entities', including staff and external organisations, to support effective 'connection between an organisation and its environment'); and

controlling and monitoring (holding the organisation to account in meeting its objectives).

Denis et al suggest that these governance functions are related to the organisation's culture and values and its adaptation to environmental changes. They argue that these factors, in turn, directly influence achievement of three 'organisational goals' of healthcare services: 'stakeholder satisfaction', 'population effectiveness' and 'institutional development'. According to this framework, achievement of these goals contributes to the overall sustainability of the organisation and its systems (20).

Following Denis et al's framework of governance – and incorporating the issue of accountability and the distinction between governance and

management – we propose that the roles of Boards are as outlined in Figure 2 (below):

formulating strategy to meet an agreed organisational vision;

ensuring that the organisation can be held to account for its progress in achieving its strategic goals and that suitable systems are in place to support this process; and

shaping culture within the organisation.

In carrying out these roles, the key supports for Boards are:

understanding the context in which the organisation exists;

shaping and using intelligence that reflects the organisation and its users; and

engaging with staff, patients and the local community.

Figure 2. The roles and 'building blocks' of Board governance

4 The Role of NHS Boards

NHS guidance suggests that ‘successful organisations are led by successful boards’ (2). Reviews of Board activity and effectiveness (in both healthcare and non-healthcare domains), however, indicate that further research is required on how (and how well) Boards perform their role and what effect this has on the organisation (31-33). Although some empirical research on NHS organisations has found an association between better rated leadership and better performance on measures of service quality (34), care must be taken when interpreting such findings (as detailed in Section 2).

The established dual role of Boards – NHS or otherwise – can be summarised as ‘shaping strategy and ensuring accountability’: setting a suitable organisational direction and being assured that this is reflected in practice. This is reflected in healthcare and non-healthcare settings, both in guidance (1, 6, 8, 9, 25, 29, 35) and research (33, 36). There is an increasing recognition in guidance of the important role Boards have to play in fostering a suitable ‘organisational culture’ (1, 2, 9, 37, 38).

The following subsections outline the key roles of NHS Boards – formulating strategy, ensuring accountability and shaping culture – and summarise relevant guidance and relevant research evidence where possible. A further subsection discusses priority areas to which Boards might contribute through these roles.

4.1 Formulating strategy

It is recommended that Boards should first agree the organisation’s purpose and values and then develop a strategy supporting the organisation in achieving these (1, 9, 21, 29, 39). Guidance from the OECD emphasises the importance of incorporating high ethical standards into strategic objectives (40). The NHS Constitution – which all NHS bodies must by law take account of in their decisions and actions – outlines the core values and principles of the NHS (Figure 3). While recognising that specific values should be developed in response to local factors, these values are presented as common ground for NHS organisations (3).

Figure 3. NHS principles and values

NHS principles	NHS values
A comprehensive service, available to all	Respect and dignity
Access based on clinical need, not ability to pay	Commitment to quality of care
Highest standards of excellence and professionalism	Compassion
Reflecting needs and preferences of the public	Improving lives
Partnership across organisational boundaries	Working together for patients
Best value for taxpayers' money	Everyone counts
Accountability to the public, communities and patients	

Drawn from the NHS Constitution (3)

It is recommended that strategy is stated clearly, incorporating outcome-focused goals that are suitably challenging, but achievable (25, 35, 41). It should reflect current contextual drivers and pay suitable regard to likely future priorities. The recommended timescale for strategy generally ranges from three to five years (1, 8, 25, 29, 31, 42).

As outlined in later sections, strategy has a significant role to play in assuring Boards that the organisation addresses such important factors as quality (Section 4.4.1), risk awareness (Section 4.2.1), innovation (Section 4.4.3) and value for money (Section 4.4.2).

Guidance drawn from NHS and non-NHS domains suggests that Boards revisit strategy regularly, reflecting on objectives and the organisation's progress in meeting them (6, 41, 42). Recommended components of strategic discussions include market and business development; trends and forecasts on key elements of organisational performance (see Section 7.2); and the nature and potential impact of future developments in the external environment, such as policy and technology (see Section 7.1) (41, 43, 44). Case studies in both healthcare and non-healthcare domains have noted the negative impacts of inappropriate strategy and the difficulties that may arise when there is a failure to respond appropriately to intelligence indicating the need for revision (13, 45).

NHS guidance on governance and commissioning notes the importance of recruiting and developing a suitable workforce to meet organisational priorities and identifies the role that strategy plays in supporting this (2, 46); guidance on corporate governance tends not to refer to workforce development explicitly (6, 8, 29). As with other elements of strategy, reviews of the literature recommend that workforce development strategy should take both long term and short term perspectives, recognising that change is inevitable and should be prepared for, for example through scenario planning (42, 47). It should incorporate intelligence, such as local population needs and workforce capacity required to meet these (for example, the necessary employee skills

and numbers),learning from the ways in which other organisations address workforce issues, and the wider context of national policy and regulation. Reviews note that workforce strategies may be tailored to fit the various sections and levels of the workforce, meaning that more complex organisations may require a more complex strategy (42, 47). Engagement and involvement of the workforce and other stakeholders (Section 7.3, 7.4 and 7.5) is identified as a key factor in informing an effective development strategy, as well as in building consensus on it (42). It is noted in these reviews that the link between strategy, workforce development and improved outcomes is not – as yet – supported by a strong evidence base. As is the case in many other sections of this review, the need for further systematic evaluation is identified (42, 47).

A review of board effectiveness notes the value of Board members' experience in formulating strategy (33), while research on workforce development strategy indicates that Boards tend to get better at this with practice (42). A survey of NHS perspectives indicates that a short term focus still dominates many Boards (48), while research on NHS Board members notes that, while respondents identified strategy as a key activity, observations of Board activity revealed that operational matters and meeting external targets tend to preoccupy discussions, leaving strategy sidelined (49). This would not only limit the readiness of organisations to meet an unpredictable future, but also reduce Boards' opportunities to strengthen their strategic skills.

Finally, a review of literature on corporate firm performance emphasises the importance of translating strategy to frontline activity: "15% of the benefit from strategy came from the intrinsic excellence of the strategy itself and 85% from the excellence of the implementation, which is primarily achieved through programme management" (50). This indicates that Boards should be assured the organisation is supported by suitably skilled management personnel, and that Boards engage effectively with them, for example through the CEO and executive directors.

4.2 Ensuring accountability

NHS and general corporate guidance recommend that Boards should be assured that a formal and transparent system is in place to hold the organisation to account in its efficient and effective achievement of strategic objectives, while not having to engage in operational micro-management (1, 8, 9, 30). This system should support identification of and response to significant risks (for example financial performance and service quality – see Section 4.4); internal and external reporting of a suitably high quality; and compliance with laws, regulations and internal policies. An example of ensuring external accountability recommended by NHS policy is the publication by NHS organisations of 'quality accounts'. These allow public scrutiny of organisations on key measures of service quality and patient safety (2). The development of 'quality and risk profiles' (51) may also provide

individual providers with a means of demonstrating their compliance with external quality drivers to regulators.

The internal control system is formed of policies, processes, tasks and behaviours (1, 8, 9, 30); and it should be outlined in a Statement of Internal Control (9, 52). It is recommended that the system should be reviewed continuously and assessed at least annually (29, 30).

4.2.1 Risk management

It is recommended that risk should be central to Boards' decision making role. It should inform organisational strategy and allocation of resources, ensuring existent risks are addressed and potential risks are identified proactively (1, 8, 9, 21, 40, 53). Corporate guidance suggests that a non-financial organisation's principal risks should be tied to its 'central product or service offering… with financial risks as important but subordinate' (8).

In terms of structure, the Walker review (8) recommends that, to provide scrutiny and oversight of risk, Boards establish a Risk Committee and appoint a Chief Risk Officer (CRO), which feed high level information to the Board . This view is supported by research in the commercial sector, which notes that Audit Committees have become increasingly involved in risk management, but suggests they lack the time and expertise required to review data in sufficient detail; instead, a dedicated Risk Committee and CRO are recommended (54, 55). Guidance recommends that risk information to be considered by the Risk Committee should be detailed in the risk register: this should cover the organisational strategy from a risk management perspective and be updated regularly (9, 54).

Guidance drawn from private sector experience suggests the Risk committee's report should place strategy within a risk management context, consider potential risks (their nature, level and level of change over period), and outline existent risk management practice (8, 40).

To support development of a suitably informed and risk-aware strategy, guidance recommends that Boards should establish an effective risk management system (1, 8, 9, 29). An international consultation carried out by the OECD in the wake of the 2008/09 financial crisis suggests widespread failure of risk management was due to disconnection within the risk management system, for example from strategy and other management systems (56).

It has been suggested that managers, staff and service users should be engaged in the risk management system, for example by reviewing critical incidents and identifying potential incidents (27). Research indicates that such input may benefit strategy and that such engagement is important in reflecting and cementing personnel's ownership of risk (23, 55, 57). To ensure such engagement, guidance and reviews of research recommend that Board members also engage – and are seen to engage – in these processes (23, 27, 57).

4.3 Shaping culture

Culture is recognised increasingly in guidance as a key factor in the functioning of healthcare organisations (27, 37, 58, 59). Boards are viewed as having a significant role to play in this: by setting its values, guidance suggests that Boards 'set the tone' of the organisation's culture (1). In addition to organisation-specific values, guidance on good governance emphasises the importance of embedding the Nolan principles of selflessness, integrity, objectivity, accountability openness, honesty and leadership at all levels of public service organisations (21, 60, 61). Scandals sharpen awareness of the importance of such values and ethical practice at regular intervals, for example with Enron, which developed a culture that lacked transparency and openness, exemplified by the Chair and CEO omitting to inform other Board members of questions raised over financial irregularities (62).

Examples suggesting Boards' influence on 'organisational culture' can be found in such domains as quality (Section 4.4.1) (1, 2, 9, 37, 38) and innovation (Section 4.4.2) (63). This can be supported through Board engagement with management and staff to communicate organisational values (64), for example by participating in 'walk rounds' and making personal statements (27, 63, 64). An example of guidance on change in the NHS notes the importance of aligning organisational culture with organisational vision, engaging staff in well-planned initiatives that are nuanced sufficiently to reflect the variations within the organisation (59).

It should, however, be noted that such constructions might be simplistic. An analysis of the literature exploring the influence of organisational culture on organisational performance in healthcare settings reported that, while such a relationship has an 'intuitive appeal', little firm evidence in support of it could be found (19, 65). The review notes that 'culture' might be assessed on numerous levels, ranging from explicit activities through to unspoken local assumptions that might only be accessed by inference; and it presents a typology that might be used in analysing organisational culture. The review notes challenges in defining 'culture' and 'performance', acknowledging their complex, multilayered and at times overlapping, interactive natures. It also reports that much of the research accessed was cross-sectional in nature, making it difficult to establish the direction of causality in any associations found between culture and performance. The review warns of unintended consequences of attempts to effect culture change, some of which might prove to be dysfunctional.

Similarly, there is debate in research literature on the relationship between leadership, culture and performance: specifically, whether 'good' leaders shape 'good' organisational culture or are merely an outcome of it. Most evidence supports the former position, that leaders do influence culture as recommended in guidance (66). A study of CEO leadership style in Chinese firms draws the distinction between "performance builders" and "institution builders". It concludes that the latter style – with a stronger focus on delegation and systems development – is more likely to build a strong culture,

with senior and middle managers more likely to support transmission of organisational values to staff (67).

Research carried out in the NHS also suggests associations between leadership, culture and performance (68). 'High performing' and low performing' hospitals were selected based on the Department of Health's rating system and senior managers and clinicians in these hospitals were interviewed about aspects of organisational culture. The study found that 'high performing' hospitals tend to have leaders who are viewed as rational, with a focus on communication and accountability, supported by well-integrated and corporate management, empowered middle management, and effective information and performance management systems. 'Low performers' are characterised as having charismatic, capricious leaders, with cliquish management culture, under-developed middle management and information systems, with 'challenging senior management' a key taboo (68).

More recent NHS-based research suggests a more nuanced relationship between management culture and performance in the NHS setting (69). Focusing on NHS hospital senior management, the 'competing values framework' is used to categorise hospital culture along dimensions of process and focus and categorise these organisations as having a clan, developmental, hierarchical or rational culture; hospital performance was then measured on such variables as quality, activity, access, and financial performance. It was found that hospitals tend to perform better on measures of performance that reflect what is valued within their organisational cultures. For example, hospitals with cultures classified as 'clans' (internally focused organisations, with a participative leader and relationship-based processes) will perform poorly on external measures, but have a high focus on staff morale and patient dignity; hospitals with rational cultures (externally focused, with a competitive acquisitive leader, and control and order-based processes) will tend to be larger, more interested in research activity, but less interested in staff morale (69).

The research above suggests that Board and organisational culture are related; and that these might influence the level and nature of organisational performance. As yet, the nature of these relationships – and the processes underlying them – is not well understood. Further research may identify in more detail how culture and performance interact, as well as what the Board's role is in this dynamic.

4.4 Priorities

In considering some measures that reflect organisational performance, this section addresses topics identified in guidance and the NHS Constitution as factors on which NHS organisations should focus in fulfilling their obligations to the public (2, 3). It presents guidance and research describing why these factors are important and how Boards contribute to NHS organisations achieving them.

4.4.1 Quality and patient safety

Quality of care is defined in NHS guidance as being clinically effective, personal and safe (2). Quality is identified as a core value of the NHS (2, 3); and it is recognised increasingly as an important marker of well-governed healthcare organisations (2, 9, 37, 41, 58). Guidance encourages Boards to make this a central organisational value and dedicate a significant proportion of their attention to the matter (27). Research indicates that governance and Boards have a key role to play in supporting quality services (23, 41, 70, 71). Examples are detailed below.

In establishing organisational direction, research suggests that Boards setting quality and safety as an organisational value increases its prominence in strategy. This, in turn, is reflected in an increased focus on quality on the ground, in the form of team priorities, improvement initiatives and resources (23, 72). A study of US healthcare reported that 'high performing' healthcare organisations are more likely than 'low performers' to identify quality as their top priority and identify specific quality measures – such as Healthcare Associated Infections and medication errors – as organisational objectives (70). To encourage such prioritisation, research indicates that tying Board compensation or remuneration to quality performance can also influence quality outcomes (23).

Research notes the value of placing quality and safety as a standing item on the Board agenda (23, 26, 33, 70). Placing it at the top of the agenda can increase the attention given to the subject across the organisation (27), while dedicating significant Board time to the subject (20+%) is associated with improved quality outcomes (23). Research with NHS Chairs indicates that time dedicated to quality discussion varies: while estimated to be of this level, it is not of a consistent or guaranteed length (26).

As with other organisational priorities, guidance recommends that Boards should establish information systems to be assured that the organisation is performing suitably on national and local quality targets; and that these data should be presented to Boards in an easily digested summary, covering a small number of critical indicators, for example as a performance indicator-based 'quality dashboard' (2, 9, 27, 41). Research suggests better Board oversight of quality information is associated with superior performance on such indicators as mortality, morbidity and complications (23); a study reported that Boards of 'high performing' healthcare organisations in the US are significantly more likely to receive and use a quality dashboard (70). However, in a study of NHS Board members, they cautioned that use of the dashboard can be counterproductive: items not featured on the dashboard can receive insufficient attention; while featured items, if scored 'green', risk falling 'into a black hole' (26).

To engage suitably with this information, guidance recommends all Board members should be aware of quality and safety issues; this should be reflected in member competencies and ensured through education and review (23, 27, 70). This recommendation is supported in research, with high

performing organisations reporting significantly higher levels of quality expertise amongst Board members and greater availability of Board quality training programmes (70). Higher levels of quality expertise on Boards – for example by ensuring that at least one Board member has specialist knowledge of quality, whether in healthcare or another domain – can enhance the focus on and understanding of quality when establishing strategies and systems (23).

Another way in which Boards might ensure that quality issues are addressed is by establishing a quality committee, which dedicates its time to detailed scrutiny of information, and generating key summary information for the Board (26). Evidence suggests that quality committees are becoming more common (33) and that they can enhance Board oversight of quality performance by ensuring input from people with quality expertise, such as clinical, nursing, management and non-healthcare domains (23).

Research suggests that Boards should consider engaging with management personnel, clinicians and patients to gain greater understanding of quality issues within the organisation and feed this learning into strategy (23). A review of research suggests that by increasing Board engagement with such perspectives might lead to the development of more meaningful, effective strategy (23, 33) (engagement is discussed further in Sections 7.3 and 7.4).

A culture that prioritises quality and safety may be an important factor in healthcare organisations meeting their quality objectives. Research in the healthcare domain suggests that, in such a culture, staff are more likely to engage with incident reporting systems, with better reporting and learning from errors (26). Board influence on organisational 'safety culture' is well-recognised in guidance (1, 2, 9, 37, 38). Research indicates that Boards can contribute to this through visible engagement with the quality agenda, for example by participating in 'walk rounds' where board members discuss safety issues with frontline staff; by distributing 'safety briefings' across the organisation, covering key issues and performance data; and by establishing quality training and education programmes for all staff (23, 27, 70).

4.4.2 Resource management and productivity

Regardless of the economic climate, it is important that NHS organisations – as is the case for all public service organisations – provide value for money (2, 3, 73, 74). Research on human resource management indicates that for-profit business models are likely to benefit the productivity of non-profit organisations (75).

NHS guidance notes that beyond the shared Board responsibility for financial management, the CEO (as Accountable Officer) is individually responsible for this element of performance (76). NEDs are expected to perform their established roles of scrutiny and challenge with regard to strategy, systems and data (7, 41, 77). It is therefore important that Boards make productivity and resource management a focus of their work (29, 41).

It is recommended that Boards should be guided by the Audit Committee, which scrutinises and recommends financial accounts and provides interim reports to the Board. It should be composed exclusively of independent NEDs, of whom one should act as Chair (7, 8, 29, 78, 79).

In addition to corporate responsibilities as a Board member, the Finance Director (FD) is identified in guidance as having key responsibilities, including financial governance and assurance, providing business and commercial advice to the Board and securing best value for money (76). Additional, organisation-specific FD responsibilities (for example in PCT, FT and SHA contexts) are noted in guidance; it is recommended that the FD should have financial experience from both public and private sectors; and that this might be supported through networking, education and support from NEDs (76).

Research has considered the potential importance of effective board governance in ensuring productive and resource-effective healthcare organisations. Using the *Board Self-Assessment Questionnaire* – which rates Boards in terms of contextual, educational, interpersonal, analytical, political and strategic competence – a study found that ‘better’ boards tend to lead hospitals that are more profitable and have lower expenses (80); this finding supports earlier work linking effective Board dynamics to organisational success (62).

Guidance on performance intelligence (Section 7.2) suggests that Boards receive and discuss ‘exception reports’ detailing where the organisation’s performance on financial and efficiency measures falls outside expected levels (41). In support of this, a standardised system of financial reporting is recommended (54). Guidance has also suggested that “Service Line Reporting”, where financial performance is broken down across services, might aid productivity (81).

A review of resource management in healthcare emphasises the importance of incorporating value for money into all decision making and strategy. It outlines how ‘value for money’ might be calculated. In describing ‘value’, the report identifies five components that might be measured: health gain (for example Quality-Adjusted Life Years (QALYs), patient experience, inequalities (in health and in access to health), broader economic outcomes (reduced use of services; and activity and processes. For each of these measures, the report notes varying degrees of subjectivity and uncertainty. Even in terms of ‘money’ – which might be thought the more concrete element – the report notes difficulties, including the complexity of costing activity accurately, due to the difficulty of estimating specific contributions made by personnel over time, and identifying indirect costs, such as transportation to and from services (82).

4.4.3 Innovation

NHS guidance identifies innovation as a foundation to offering the best available service. It is recommended that Boards support innovative approaches to service delivery and notes that there exist several drivers that encourage and incentivise innovative healthcare organisations (2, 27). A

review of research notes a longstanding recognition of the positive association between innovation and organisational performance (83); when resources are limited, however, organisations are tempted to avoid innovative behaviour (84). Corporate guidance suggests a failure to innovate is likely to limit the development of organisations in challenging times (8). This is especially important in healthcare, which faces a rapidly changing context (for example in terms of finance, case mix and public expectation – discussed further in Sections 4.4.4 and 7.1).

Interestingly, a review of the literature indicates that large healthcare organisations tend to be more innovative (85). Boards might support innovation through their identified responsibilities for structures, systems and culture, though it should be noted that a substantial review of the literature concluded that the evidence base for Board influence on innovation is limited (85).

Innovation-friendly organisations are characterised in research as having a decentralised but clearly defined structures. It is important that Boards avoid a top-down, rule-driven approach that can limit innovative behaviour (63, 85). For example, Boards may encourage clinicians to take the role of ‘change agent’, leading innovative work (63). Such decentralised structures can encourage frontline and managerial personnel to innovate by allowing them the freedom to make their own decisions and take their own risks (48, 63, 84); linking incentives – such as finance and time – to such behaviours might also aid innovation (63, 84).

Systems that monitor, evaluate and learn from innovative activity are important. These assure Boards that innovative risk-taking is not occurring at the expense of safety, whilst also demonstrating and recording the effects of innovations, thus building a local evidence base by which future innovations might be informed (48, 64, 84). Research suggests that much innovative behaviour depends on effective communication: whether ‘looking out’ and learning from other organisations, or encouraging the spread of information across professional groups and organisational layers, Boards’ endorsement of communication is a key support of introducing and spreading innovations (63, 85). This can be facilitated by supporting development of networks and collaboratives within and beyond the organisation (63). Some empirical work indicates that the most important form of communication in support of innovation is ‘cross-divisional’, i.e. across different sections of an organisation, rather than within a section, or across different organisations (86).

Finally, it has been recommended that Boards have a responsibility to embed innovation in the organisation’s culture (63). Research on organisational innovation indicates that while leadership can encourage innovative behaviours, this is mediated by organisational culture, where free discussion and experimentation are common (66). An important means of supporting such culture is Board engagement with management and staff (64): guidance and research indicate that being seen to support innovation and innovators – for example through Board members participating in ‘walk rounds’ and making

personal statements on the subject of innovation – can encourage staff to engage in the established structures and systems (27, 63, 64).

4.4.4 Population health

NHS guidance outlines the significant challenges that face health services as they attempt to meet ongoing shifts in public requirements driven by changes in demographics and lifestyle. Boards are advised to focus on the current and changing needs of the people the organisation serves (2, 3, 41, 43, 44, 46, 87). As mentioned in Section 4.2, it is important that Boards and the established risk management structure incorporate impending as well as existent risks (1, 9). Guidance for NHS organisations notes the importance of regular and robust needs assessments as a means of understanding current and future local health requirements, incorporating perspectives of patients, regulators, commissioners, clinicians and managers (41, 44, 46).

Guidance for PCTs recommends that understanding the health needs of the local population is supported through good liaison with local partners (such as acute services, mental health services, social services, local authorities, the voluntary sector), to ensure meaningful data are accessed (see Section 7.5); and the importance of effective data management and data analysis is also noted (for example using predictive modelling and scenario planning to assess trends and consider responses; and process mapping to consider the patient pathway options available in existing services) (46). Guidance for all NHS organisations suggests that routinely collected data (accessed from admission patterns or GP practice, for example) might be analysed to identify communities whose uptake of services is low (41); while guidance for PCTs identifies further factors, including income, age, ethnicity, sex and lifestyle characteristics that may predict increased likelihood of high-risk conditions (46).

4.4.5 Equality and diversity

Ensuring that all sections of society have equal rights and receive equal consideration is a key driver in NHS guidance (2, 3). A review of Board member behaviour suggests that greater diversity might support improved independent challenge (31). A review of board effectiveness in across a number of sectors reported that 11% of Board seats were occupied by women (33). It has been reported that the proportion of appointments of NEDs and Chairs from groups currently under-represented in these roles is as follows (88):

people from BME communities – 11.7%

disabled people – 4.5%

women – 33.7%

The Department of Health provides guidance and support on the legal obligations of NHS organisations regarding equality and human rights (89). This outlines the CEO and executive directors' personal accountability for

ensuring the organisation's compliance with equality and human rights legislation, alongside the Chair's responsibility to ensure equality is central to board activity and the NEDs' general responsibility to challenge executive proposals with an equality focus.

Guidance on commissioning to reduce inequalities notes the importance of knowledge of local need (44); a key support in this is engaging effectively with local communities and this may be aided through ensuring suitably diverse representatives on Boards (see Sections 7.2 and 7.4). A review of Board effectiveness reports little evidence to suggest that diversity leads to improved effectiveness (33). Understanding of how Board dynamics influence organisational performance remains limited, however (Sections 4.3 and 8.6), which makes such a finding unsurprising. Future research into the 'black box' of Board dynamics is likely to benefit from exploring the relationship between a Board's diversity and its culture.

5 Individual Board roles

As outlined previously, many responsibilities are shared by Board members (Section 4). There also exist specific Board roles, however, and it is recommended that these are suitably understood (8, 29, 31, 39, 40, 90). The following subsections cover specific features of key positions occupied in Boards. A discussion of how these various roles interact is presented in Section 8.6.

5.1 The Chair

The role of Chair is to 'ensure the Board gets its job done' (25). Corporate governance guidance states that the Chair is responsible for leading the Board and setting its agenda and ensuring it is evaluated regularly; ensuring that clear and accurate information is communicated in a timely fashion within the Board (for example between executive and non-executive members) and with shareholders; and supporting a constructive dynamic within the Board, with all directors making a suitable contribution (8, 29). Research carried out with NEDs in the corporate domain suggests that effective Chairs add value to Boards by supporting relationships – with investors and colleagues – and by contributing intellectual and ethical input in Board discussions (5).

NHS guidance and regulation outline broadly similar leadership roles for Chairs (1, 9, 10, 90-93). However, given the public accountability of NHS organisations, the role of NHS Chairs extends to engaging with stakeholders such as partner organisations and members of the public, and ensuring information on such matters as policy are communicated to the Board (1, 10, 90).

Chairs of Primary Care Trusts have a particular role in forming a strong relationship with Chairs of Professional Executive Committees (1). In NHS Foundation Trusts, in addition to leading the Board, Chairs are required to lead the Board of Governors (10).

Corporate guidance developed in response to the 2008/09 financial crisis recommends improving the processes for appointment of the Chair, requiring evidence at appointment of financial experience and, in particular, leadership skills (8). It is also recommended that the majority of the Chair's time – and probably not less than two thirds – is dedicated to supporting the organisation (8). A study of Board member activity found that Chairs who lead high-performing healthcare organisations dedicate greater time to their role outside Board meetings than those who do not (94).

5.2 The Chief Executive Officer

Guidance from the corporate sector describes the role of the Chief Executive Officer (CEO) as leading the executive, with responsibilities for day-to-day management of the organisation (95). It is recommended that the CEO

ensures the Chair and directors are suitably informed of the organisation's progress (95). In line with this, reviews of corporate boardroom dynamics identify the Chair/CEO relationship as important to the functioning of Boards and the whole organisation (31, 62, 96) (discussed further in Section 8.6). Along with the Finance Director, the CEO should be the main point of contact with shareholders (29). In the event of departing the role, it is recommended that the CEO does not become Chair of the same organisation without shareholder consultation (29).

In all NHS organisations, the CEO's management role is similar, with accountability to the Board for achieving its objectives (1, 10, 97-100), though again the public nature of NHS organisations means the CEO has additional accountability. As designated Accounting Officer in Foundation Trusts, CEOs are accountable to parliament and 'has responsibility for the overall organisation, management and staffing of the NHS Foundation Trust and for its procedures in financial and other matters'(101). As Accountable Officer in other NHS organisations, the CEO is accountable to the Chief Executive of the NHS for ensuring his or her organisation operates 'in a way which ensures the proper stewardship of public money and assets' (98-100).

Corporate guidance warns of the dangers to Board dynamics that arise when an established, successful CEO becomes an 'entrenched' one; and notes that, under such circumstances, NED challenge becomes increasingly important, if perhaps also correspondingly difficult to carry out (8). Research indicates that this might not be a common problem in the NHS, however. A report on senior executive directors estimates the current average tenure of CEOs in the NHS to be 700 days and notes that less than 5% of those who leave their position do so due to reaching retirement age (102).

5.3 Non-Executive Directors

In carrying out their corporate responsibility, NEDs share numerous roles with the rest of the Board (Section 4). Corporate and NHS guidance overlap in recommending that key roles of NEDs include constructive challenge of executive strategy, scrutiny of management performance in meeting goals and targets; monitoring reporting of performance; and contributing to decisions on appointments and remunerations (1, 7-10, 29).

In addition to these responsibilities, guidance states that NEDs in NHS organisations are accountable to the public to ensure appropriate services are provided and that funds are used effectively (1). It is noted that NHS NEDs, then, should have a strong understanding of NHS business requirements and understand clinical matters sufficiently to appreciate the consequences of the organisation adopting a given clinical approach (9). In Foundation Trusts, NEDs are accountable to the Chair and Board of Governors.

It is also suggested that NHS NEDs may be tasked with 'championing' certain elements of health policy, to ensure such topics are addressed suitably by Boards (1) and ensuring that quality remains a central focus of Boards (9). Given that the Chair's role includes setting the agenda (Section 5.1), and that

useful guidance on agenda and annual timetabling exists (Section 8.5), this role may be seen as unnecessary. However, as concerns remain over effectiveness of timetabling and agenda-setting in practice (Section 8.5), 'championing' may still be a useful support.

In the private sector context, NEDs appraise the Chair's performance, while incorporating views of Executive directors, at least annually. This process is led by the Senior Independent Director (SID) (Section 5.5) (29). The same appraisal process is recommended in NHS Foundation Trust guidance, incorporating the views of the Board of Governors (10). Appraisal of Chairs of NHS Trusts and Primary Care Trusts are carried out by the Chair of the local Strategic Health Authority, while appraisals of Chairs of Strategic Health Authorities are administered by Appointments Commissioners (1).

Guidance drawn from the private sector recommends that NEDs should dedicate a minimum of 30-36 days per year to this role (8); this is in line with current NHS guidance, which suggests that NEDs should be able to carry out their role in 2.5 days per month (1). NHS guidance raises the possible risks of NEDS adopting responsibilities beyond those recommended, noting that this may have a negative impact on their stipulated role (1).

In corporate guidance, 'independence' relates to the potential for conflicts of interest, for example by having been employed by the organisation, or having family or business ties with the organisation (29); it is recommended that 50% of Boards – excluding the Chair – should be independent (8, 29). UK and international corporate guidance notes the value of independent NEDs in addressing issues that entail potential conflict of interest, such as financial reporting (40). It is recommended that all NHS organisations maintain a register of interests, detailing any conflicts (1, 10, 52).

5.4 Executive directors

Guidance from the corporate domain describes the role of Executive Directors (EDs) as making strategic proposals to the board – under the CEO's leadership; and, following Board discussion, executing the agreed strategy (8). NHS guidance suggests that Executive directors help set the vision for the organisation by drawing on local and national context; collaborating with and – directly and indirectly – influencing internal and external stakeholders. Research drawn from corporate and NHS domains indicates that EDs can support effective operations by facilitating the link between Boards and management (36), aiding teamwork and removing barriers to improvement (103).

A review of corporate governance in financial services recommends that EDs should form a cohesive group and not be dominated by any single voice. It also outlines the potential value of featuring executive members in addition to the 'core' CEO and Financial Director, noting that this reduces the risk of Boards becoming over-dependent on a small number of individuals (8). NHS guidance appears to reflect this good practice, with the recommendation that

NHS Trust Boards feature up to five EDs, including CEO, Financial Director and Medical Director (104).

5.5 The Senior Independent Director

Corporate guidance recommends that Boards should appoint from amongst its independent NEDs a Senior Independent Director (SID). The SID leads the NEDs in assessing the Chair's performance and acts as a point of contact for shareholder concerns when approaching Chair, CEO or Finance Director is felt to be inappropriate; and therefore should attend sufficient meetings with a range of shareholders to ensure sufficient understanding of their concerns (29). Corporate guidance proposes greater recognition of the importance of the SID, noting the value of the role as sounding board for the Chair, overseeing the Chair/CEO relationship (ensuring it becomes neither too fractious nor too cosy) and as a means of reminding NEDs of their duty to challenge the Executive (8).

The SID is also identified in NHS Foundation Trust guidance, carrying out a similar role, acting in addition as a point of contact for the Board of Governors (10).

6 Board committees

As outlined in Section 4.1, effective strategy benefits from suitable inputs. Well selected and presented intelligence is important, but guidance recommends that there are domains in which the Board benefits from additional support by the creation of Board committees (1, 6, 8, 9, 29).

Board members may have limited time in which they can contribute to their work for an organisation (Section 5). It is noted in previous NHS guidance that Board committees represent a significant investment of time; and it is suggested that only a small number are required to be permanent; for other pressing matters, guidance recommends the creation of time-limited committees (1, 9). UK corporate guidance recommends a rigorous annual review of the Board committee structure (29) and this is reflected in NHS guidance (9).

Guidance on which committees should be permanent varies across domains. In corporate guidance, a core of *Audit*, *Remuneration* and *Nomination* committees is recommended (8, 29). As mentioned in Section 4.2.1, corporate guidance suggests the addition of a permanent *Risk* committee (8). In the NHS, there has been more variation, with some guidance suggesting the following as permanent Board committees: *Audit*; *Remunerations & Terms of Service*; *Clinical Governance*; *Risk Management*; and the *Professional Executive Committee* (for PCTs) (1). Other NHS guidance suggests that healthcare organisations have, on occasion, formed too many committees and recommends only *Audit*, *Appointments*, and *Remuneration & Review* committees, while suggesting other possible permanent committees include *Risk Compliance & Assurance*, *Health and Safety*, and *Clinical Governance* (9). Guidance specific to NHS Foundation Trusts recommends creation of *Audit*, *Remunerations* and *Appointments* Committees (10). Research on how governance might influence quality and safety recommends that healthcare organisations put in place a dedicated *Quality Committee* (23, 70).

International corporate guidance states that it is important that the purpose, duties and composition of Board Committees are communicated clearly (40) . The following subsections outline the key Board committees, their composition and their contribution to organisations.

6.1 Audit Committee

In corporate guidance, the Audit Committee has responsibilities for monitoring internal processes, such as financial control and audit; and supporting the organisation's independent external audit processes. It is recommended that it should feature at least three independent NEDs; the Chair may be a member of this committee, but may not chair it (29, 79). NHS guidance on Audit Committees is similar to corporate guidance, though Chairs are not permitted membership (1).

Research indicates that it is important that all NEDs who sit on Audit Committees should have independent status. It is suggested that only under such circumstances are the benefits of having an Audit Committee obtained, for example in terms of monitoring performance and ensuring that external auditors are not unduly influenced by management (105).

6.2 Remuneration Committee

Guidance from the private sector states that the Remuneration committee is responsible for setting remuneration for all executive directors and the Chair; and recommending and monitoring remuneration for senior management. It should be formed of at least three independent NEDs; the Chair may be a member of this committee, but may not chair it (29). Corporate guidance developed in the wake of the financial crisis of 2008/09 recommends extending this committee's function to encompass all aspects of remuneration policy and using deferral of incentive payments as a means of encouraging sustainable performance (8). In NHS Foundation Trusts, the Remuneration Committee sets remuneration of Executive Directors, while the remuneration of NEDs and the Chair is set by the Board of Governors (10). In other NHS organisations, the Remuneration Committee sets remuneration for executives, whilst the Appointments Commission sets remuneration for NEDs and the Chair (1). NHS guidance on Remuneration Committees recommends that remunerations packages should link Directors' responsibilities with their associated rewards and that this information should be documented clearly. It is also recommended that arrangements should reflect equal pay requirements (106).

A review of Board effectiveness suggests the importance of there being the 'right' remunerations policy in place – ensuring a suitable quality of candidate who will commit appropriate time and effort to the role (33). A study of a substantial international dataset, analysing the relationship between remuneration of CEOs, directors and firm performance, suggests that the responsibility borne by Remunerations Committees is great. The study finds CEO and director excess remuneration to be positively associated and, in turn, negatively associated with firm performance. Having corrected for potentially relevant factors – such as firm characteristics – the authors conclude that this pattern reflects difficulties in Board culture, ineffective monitoring and a failure to protect shareholder interests (107).

6.3 Quality Committee

As mentioned above, a dedicated Quality Committee has been recommended by a number of research studies (23, 70, 72); whereas quality is only included as a component of Clinical Governance committees in NHS guidance (1, 9). However, quality and safety is central to any healthcare organisation and it is important that Boards receive suitable support in addressing this issue.

A review of research on quality and safety supports the addition of a Quality Committee, noting research reporting associations between the presence of such a body and lower mortality levels; it also emphasises the importance of a

membership that is suitably knowledgeable of quality issues (23). Further research indicates that high-performing healthcare organisations were significantly more likely to have a quality committee (70).

6.4 Nominations Committee

In corporate guidance, the Nominations Committee leads the process for appointments to the Board and supports succession planning (7, 29). It should support appointment of a well-balanced and suitably committed Board, based on objective, explicit criteria; and the majority of its members should be independent NEDs (29). The Chair or an independent NED should chair; the Board Chair should not chair when his/her position is under discussion (29).

Nominations Committees are also recommended in NHS Foundation Trusts, with the caveat that two committees, addressing executive and non-executive directors respectively, might be formed. In Foundation Trusts, Governors are responsible at a general meeting for the appointment of Chairs and NEDs, taking into account the views of the Board and information provided by the Nominations Committee (10).

6.5 Risk Committee

Recognising the increasing burden placed on Audit Committees, guidance produced in the wake of the 2008/09 financial crisis suggests Boards establish a Risk Committee separate from the Audit committee (8) (for further discussion, see Section 4.2.1).

7 The building blocks of governance

This section outlines the "building blocks" of governance: the elements upon which good governance is based. As discussed previously (for example, in Sections 3 and 4) both guidance and research indicate that good governance is built on:

- context – the external drivers over which the organisation has little influence;
- intelligence – information covering organisational performance and the local environment; and
- engagement – bridging the divide between leadership and the experiences and needs of staff, patients and the public, and local partner organisations.

The following subsections outline the evidence for the benefits of these 'building blocks' and how best to implement them.

7.1 Context

While context can be defined in numerous ways, this review defines it as the broader environment over which NHS organisations have little influence, but within which they must function effectively. Guidance notes that 'NHS Boards work within a framework of national, legal, procedural, quality and outcome standards and with professional staff who themselves are subject to a range of professional standards and obligations' (1). NHS guidance (1, 9, 41, 44) suggests that Boards can benefit from suitable awareness of the following contextual drivers:

- *policy*, which can impact significantly on NHS organisations, for example in terms of national targets, changes to organisational structures and approaches to funding services (41);
- *legislation*, including the legal requirements placed on NHS organisations and individual Board members (1, 9);
- *the economy*, which is a key factor in the funding of public services and, furthermore, may influence changes in public health demand (108);
- *regulators*, whose guidance and standards can support organisations in providing a service that complies with policy and reflects best practice (109);
- *relevant institutions*, for example professional bodies who represent and influence key groups, such as medical and nursing staff, and who might also influence policy (110); and

public expectations, where an active approach to understanding what people want from public services – for example through examining opinion polls and research – can help the Boards set an organisational vision that has ongoing relevance to the people it serves (46).

The effect of contextual influences on NHS organisations can be significant and not necessarily positive. It is suggested, for example, that the drive to meet external demands can distract from or dominate the priorities of organisations' quality and involvement agendas (23, 72, 109, 111-113). Also, the tendency for contextual priorities to change can prompt disengagement due to the sense that many priorities are not there for 'the long haul'.

It seems that key to addressing this is in setting a well informed strategy that takes a long term perspective (Section 4.1). Linking meaningful objectives to a narrative incorporating likely contextual drivers might increase the likelihood of compliance with law and regulation; and improve readiness for changes in public expectations. Guidance on well-informed governance recommends this can be achieved through 'regular horizon-scanning, together with analysis of possible impact' (41). Policy Governance suggests that such processes might be supported by accessing relevant sources of 'wisdom', including staff and academics (25); the Generative Governance approach of engaging with staff and management may offer similar benefits (23, 24).

The building blocks for assuring boards that the local community and workforce remain engaged in such a strategy are discussed in the subsections that follow.

7.2 Intelligence

A summary of the various models of governance notes that all reflect the importance of information (20). Guidance recommends that intelligence – covering organisational performance and the local environment – is vital to good governance and should be tied to Boards' strategic function, supporting constructive discussion of the relevant issues, for example market and business development, performance trends and future technological and environmental developments drawn from a full range of sources (1, 8, 25, 27, 41, 90, 114). In terms of performance, Boards should have routine oversight of the following measures: finance; efficiency; workforce; patient experience; clinical quality; access and targets (41). The value of focusing on local population health needs – and the factors that predict these, such as quality of housing – is also noted, recognising the value of engagement with local partner organisations as useful sources of intelligence (44).

The challenge of striking a balance between providing sufficient and meaningful information without overloading Board members is noted in guidance on Boards' information requirements (41). It is recommended that information should be categorised in terms of issues that should be reported routinely to a reasonable level of detail; that should only be reported in the event of divergent performance; issues that change slowly and require less frequent reporting (41).

Guidance on data quality recommends that information provided should be relevant to organisational purposes, timely, accurate, valid, reliable and complete (43, 90, 115). In being assured that objectives are being met, boards should receive performance information in a clear, easily digested format, using graphic overviews and brief commentary (41). Guidance on high quality intelligence in healthcare governance notes the importance of analysing and understanding data over time and identifying outliers (for example using Statistical Process Control (116)) as a basis for the development of exception reports (9, 41, 43); data might also be presented in the form of dashboards or scorecards, where performance on key measures is presented against nationally or locally established benchmarks (41, 117).

A review of research on Board effectiveness supports the view that provision of too much or too little information can be a significant risk to Board function. It also notes the value of timely information and the increasing popularity of dashboards (33). A review of governance's contribution to patient safety, however, reports that, while dashboards are a useful means of reporting performance, some healthcare organisations have had difficulty in establishing effective measures and consistent approaches to recording data, as well as Board members' concerns that dashboards and scorecards might oversimplify complex issues (23). Both guidance and research recommend that, in the quality context, patient stories can be a useful means of making summary data more 'real' (23, 27).

The value of Boards taking an active role in identifying the type and format of intelligence is noted in a review of effective use of information (114). For example, Somerset County Council's request for improved information led to the development of a 'value for money' tool and associated service-specific activity books. These were used to support the Council' in making difficult decisions on investment and disinvestment in services, whilst taking into account the needs of the local community.

7.3 Engaging Staff

The benefits of engagement are raised in several sections of this review. Board engagement with staff is identified as a useful means of demonstrating leadership's identification with organisational values. It can thus help Boards lead culture change, for example in encouraging staff to report to the risk management system (Section 4.2.1) (23, 55, 57) or engage in the quality agenda (Section 4.4.1) (23, 27) and financial management (118). Empirical evidence suggests that encouraging staff to share information with each other, for example about novel approaches to practice, is an important component of developing an innovative learning culture (Section 4.4.3) (86).

A report on the benefits of and best practice in engaging staff presents numerous examples of associations between improved engagement with staff and improvements in productivity and organisational culture (64). It suggests that use of established approaches, such as surveys seeking staff opinion, leave engagement as an 'add-on'. Instead, Boards should aim to achieve 'transformational engagement', where staff are integral to developing and

delivering organisational strategy (64). The report also recommends that Boards can project a 'human face of leadership' by holding 'Question Time' style events, web-chats and by distributing signed articles (27, 63, 64).

An interesting example of employee engagement is John Lewis Partnership. All employees are classified as 'partners' and receive substantial and clearly explained information about the company. All employees receive a share in profits (including an annual bonus and membership of a non-contributory final salary pension scheme) and have the opportunity to participate in committees and meetings, including the Partnership Council, through which the Chair and senior management of the organisation can be held to account by the employees (64).

7.4 Engaging patients and the public

As outlined in Section 7.2, current thinking on leadership and governance note the value of increasing Board focus on patients and the public. Weak public and patient involvement (PPI) has been identified as a potential factor in various healthcare scandals (13, 119).

NHS guidance outlines the legal impetus for such involvement, as well as describing useful approaches that might be taken in achieving effective PPI (10, 120). There are a number of examples of how best to develop service user involvement (121, 122) and how to codify degree of user participation (123, 124).

Guidance on effective commissioning outlines several approaches to engaging the public effectively. It identifies the importance of creating a trusting relationship with the local community, based on effective communication of the organisation's vision; ensuring members of the public have opportunities to share their experiences of care; and providing clarity on how their contributions will influence services. It recommends this can be supported through an effective public information strategy incorporating engagement with all sections of the community, engagement training for staff; and provision of locally-relevant health education materials (46).

A case study of a mental health trust's PPI work found that participants – both staff and service users – had positive views of the value of involvement, and could point to ways in which it had impacted in creating more user-centred services (125). A further study of service user involvement in NHS mental health services found variations in staff and service user perspectives on involvement (113). All groups recognised potential for improving services through constructive criticism, while users noted the potential benefits of empowerment through engagement. Little control was devolved from the organisation to users, with priorities of work framed within organisational objectives (for example, users were not involved in discussions of policies on compulsory treatment) and decision-making retained by service providers (justified with reference to management's accountability for the decisions made). As a result, the degree to which involvement contributed to achievement was limited due to the alignment of work with goals set by more

established and powerful stakeholders. Managers seemed satisfied to have carried out the process of involvement, whereas users focused more closely on outcomes and were correspondingly more disappointed. Key issues identified included 'representativeness' of user representatives; addressing users' expectations and supporting them in what may be an unfamiliar setting; and avoiding disenfranchisement of other groups, such as frontline staff (113).

Overall, reviews of patient and public involvement in care and service improvement report little in the way of detailed or reliable research evidence on PPI in the literature, citing inconsistent approaches to measuring involvement and impact. Consequently, it is hard to draw conclusions on how PPI might work best, or the nature of the benefits it might bring to the organisation or the public; it seems, however, that PPI is viewed positively by members of staff and the public (113, 125, 126).

7.5 Engaging partner organisations

As outlined previously (for example Sections 4.4.4 and 7.2), it is important that Boards have a clear understanding of the local environment and engage with it appropriately. NHS and UK public service guidance also note the value of 'joined up', more accountable care, for example in providing continuity of care to people with long term conditions, and recommends that a key support of this is working effectively with local partner organisations (1-3, 9, 87). Indeed, NHS organisations and other public bodies have a legal duty to cooperate on improving local health outcomes (2).

Research notes that, while 'partnership' is a popular term, there is no agreement on its definition and little clarity on how it works (127). A summary of research on inter-organisational working proposes that a partnership might be analysed on two dimensions: its breadth – the range of groups it encompasses; and its depth – ranging from information sharing, through coordinating activities, up to a formal merger of partners (22).

While engagement with partner organisations supports Boards in carrying out their roles, these roles (Sections 4.1, 4.2 and 4.3) are also central to developing and maintaining effective partnerships. It is recommended that organisational strategy should reflect a 'joined up' approach to care across partners (128); control systems featuring clear lines of accountability and suitable performance measurements can provide assurance that the partnership is operating effectively in terms of its costs and benefits (87, 128); and research on partnership between organisations notes the importance of an open culture that is receptive to such engagement (87, 129, 130).

In developing partnerships, it is recommended that Boards consider their inter organisational history (128, 129) This can be a useful way to learn from previous failures in inter-organisational working and identify where improvements might be made.

In the absence of a binding contract, partnership working depends on a degree of trust. Central to this is ensuring that there is transparency and

openness around decision making supports shared risk-taking and reduces dominance by any single voice (129)

Key challenges identified in reports on partnership working include members' 'multiple accountabilities' as they extend to include accountability to the various partner organisations; incorporating the potentially differing ways in which partners conduct business; demonstrating accountability of the partnership; and developing a performance framework that captures the various targets of all partners (22, 87, 129).

An important support of effective partnership appears to be clarity of purpose, which can be formalised through the creation of a partnership agreement. A report on partnerships in public services found that the absence of a partnership agreement can lead to increased difficulties, such as reduced achievement of objectives and even breakdown of the partnership (87). PCTs whose partnerships were not based on partnership agreements reported difficulties almost twice as frequently as PCT partnerships that had used an agreement; similarly, NHS Acute Trusts whose partnerships were not based on partnership agreements reported difficulties almost three times as frequently as those whose partnerships were (87).

While there has been a policy imperative for partnerships between organisations, the evidence of their benefits is less clear. A report on partnerships in UK public services notes that several thousand partnerships of various natures that exist, but that there is limited awareness within public service organisations of the number, nature and effectiveness of their own partnerships (87). A report on NHS organisation productivity noted that in 2008/2009 little progress was made in transferring care from hospitals into the community (131).

Research on inter-organisational partnerships and indeed more formalised integration of care organisations suggests that, while much time and effort can go into forming and sustaining partnerships, it is difficult to present empirical evidence of benefits, in terms of cost reduction and quality outcomes; much of this may be due to challenges in measurement and evaluation (87, 129, 132-134). It is reported that costs are seldom recorded effectively, in part due to the complexity of the task and in part due to concerns that the costs reported might be high. Assessing outcomes is complex because many of the most relevant areas that might benefit from partnership tend to be in addressing long-term objectives (87, 129).

8 Features of effective NHS Boards

The previous sections describe key roles of NHS Boards and ways in which Boards might carry out these roles. This section presents guidance and research evidence on features that support effective Boards. The topics selected follow those identified in guidance and previous literature reviews of Board effectiveness. Overall, these might be thought of in terms of the content of Boards, including their size, structure and composition; and the way in which Boards behave, incorporating processes and culture.

8.1 Structure

Established guidance on board composition recommends adoption of the unitary (or 'one tier') structure (1, 6, 7, 10, 21, 28, 29, 40, 79). A key feature of the unitary board model identified in guidance is the shared corporate liability amongst all board members (1, 6, 8). Research indicates that the unitary model is dominant amongst UK and US organisations, including NHS organisations (33).

Research notes the existence of an alternative 'two tier' model, which separates executive and supervisory functions across two committees. This structure is commonly used in other major western economies, such as Germany and France (33). Guidance based on UK and US experiences in corporate governance concludes that adoption of the two tier model would be unlikely to add value to organisations, stressing instead the importance of effective challenge that can take place in a well-functioning unitary board (8). International guidance published at the same time notes various potential structures (including combining unitary and two tier elements) and stresses that, regardless of structure selected, what matters is that the structure is communicated clearly and that the Board roles of setting strategy and controlling management are fulfilled (40).

8.2 Size

Established corporate guidance suggests that Boards 'should be of sufficient size that the balance of skills and experience is appropriate for the requirements of the business' (29); corporate guidance developed in the wake of the2008/09 financial crisis suggests that an 'ideal' size ranges from 10-12 Board members (8). NHS regulation states membership of NHS trust Boards may range from 8-11 members (92), Primary Care Trust Boards may have up to 14 members (93) and Strategic Health Authority Boards may range from 8-13 members; the size of specific Foundation Trust Boards is set out in their constitutions (91), while Foundation Trust guidance follows established corporate guidance on Board size (10, 29).

A review of research on Board effectiveness suggests that evidence on effective board size is mixed: earlier research reported that there is no

consistent pattern to suggest an appropriate board size; some research indicates larger boards are less efficient, while smaller boards can lack the necessary diversity of skills and stakeholder representation (33). Research on board composition suggests Board size might justifiably increase with increases in organisation size and complexity (135) and that Boards tend to feature 10-12 members (33). A study of the influence of Board size on performance in private sector organisations reports an 'inverted U' relationship, where performance is lower if Boards are 'too large' or 'too small'. The study also notes that larger Boards can add value through efficient monitoring and advising, if membership is not excessively independent (36).

8.3 Composition

Non-NHS guidance suggests Boards should feature a balance of executive and non-executive directors to ensure that power does not rest in the hands of a small number of individuals, recognising in particular the importance of independent NEDs; it is also recommended that the roles of CEO and Chair should be kept separate (6, 8, 29). NHS guidance states that there should be at least a balance of executive and non-executive directors, or a majority of NEDs (136).

Research on Board composition across organisation types has found significant variations in how 'balance' is interpreted internationally; and that these interpretations are quite different from the balance recommended in NHS Boards. For example, the executive to non-executive ratio in the US businesses is 1:5, as opposed to 2:3 in UK businesses (36), whereas guidance notes that the ratio approaches 1:1 in NHS organisations (21). A review of Board effectiveness is unable to find consistent evidence of the benefit of balancing executive and non-executive directors, though it notes the proportion of independent directors has increased following the launch of guidance to this effect (33); similarly, following guidance, organisations have increasingly separated the roles of Chair and CEO (33).

Corporate guidance recommends that Boards possess 'the appropriate range of skills, competencies and experience… to deal with the range of issues that the board confronts' (8, 29). A review of board effectiveness confirms this position, indicating that competencies should reflect the specific needs of the organisation and more general corporate team working (33).

As outlined previously, guidance and some research indicate that Boards may benefit from having members with particular expertise, for example in terms of quality and patient safety and resource management (Sections 4.4.1 and 4.4.2). Research suggests that organisations requiring a significant degree of 'insider knowledge' or that have a significant R&D focus may benefit from greater representation of 'insiders' (135, 137); Healthcare-based examples of such 'insider expertise' include the presence of medical and nursing directors on NHS Boards. A review of the corporate boardroom identifies a risk to such insightful flow of information, noting that commercial organisations, in the name of increasing NED input whilst retaining a manageable Board size, reduce the number of executive directors (31).

Whilst the independence of directors and chair is encouraged, a study of US mutual funds (collective investment schemes) does not support this principle, finding independence of chair and directors has no significant impact on either an organisation's fund performance, or on its likelihood of experiencing scandal (138).

8.4 Skills

As outlined throughout this document, numerous skills and abilities are thought necessary to govern an organisation – NHS or otherwise – effectively. NHS and corporate guidance recommends that key supports of this include suitable selection, evaluation and education processes (1, 8).

NHS and corporate guidance note the importance of having a suitably rigorous recruitment process for NEDs (8, 10, 41). Research on corporate Board effectiveness supports this, noting the importance of selecting suitably skilled executive and non-executives (33); this is also recommended in healthcare governance research, which suggests the potential benefits of recruiting Board members with expertise in quality in the healthcare setting or other domains (72). In addition to addressing skill mix, the selection process also has the potential to influence Board composition, for example in addressing levels of diversity.

Skills development is thought to be important to creating effective Boards – at both individual and collective levels. Key mechanisms by which Board members (executive and non-executive) might develop their leadership and corporate skills include the induction process and personal development plans developed following evaluation; external consultants can offer valuable insights on overall Board development (33). Corporate guidance suggests that NEDs should have access to regular training to strengthen their understanding of business activities (8).

International guidance on corporate governance suggests there an increasing tendency for Boards to encourage members to develop their skills following appointment and then to continue their development through attending in-house training and external courses (40). Other corporate guidance and review of corporate governance research, however, indicate that – in the UK private sector at least – many Board members do not receive sufficient support in this regard (8, 33).

Corporate guidance (8, 29) and a review of Board dynamics (31) note the importance of evaluating performance of the Board, its members and its committees – regularly and rigorously – to be assured that the Board is fit to carry out its roles and activities (Sections 4 and 7). In addition, it is recommended that externally facilitated evaluation of the Board as a whole should occur every two to three years (8). Guidance also recommends that any evaluation should be followed up appropriately with, for example, the development or removal of existent members, or the appointment of new members (8, 29).

Research on corporate governance notes the potential value of evaluating Boards on clear performance criteria (33, 62). A range of techniques is suggested, including benchmarking, interviewing and psychometric testing, informed by a range of perspectives, such as the Chair, fellow Board members and staff with whom the individual has frequent contact; less formal self review is also identified as a possible approach (33). A review of the evidence suggests that Boards of healthcare organisations that are in difficulties may benefit from evaluating and – if necessary – replacing Board members to ensure they are equipped with leadership skills required to bring about necessary changes (139).

Reviews note that Chairs and other Board members may resist evaluation, however (33, 140), especially when it focuses on individuals (140). It is also reported that regular external evaluation of Boards is yet to be adopted uniformly (33).

8.5 Processes

A Board's effectiveness depends not only on its structures and membership, but what it does. This section covers processes that might support effective Boards, including timetabling and agenda-setting; having suitable levels of openness and transparency.

The time dedicated by Board members to their duties is valuable, but limited (see Section 5). It is important that this time is not wasted. Corporate guidance notes excessive focus on 'process matters' in Board meetings and urges an increased focus on 'matters of substance' (8); and guidance on NHS governance suggests that many Board agendas fail to focus on key strategic issues (41). This is reflected in research, with a review recommending that Boards dedicate a suitable balance of time to formulating strategy and monitoring activity, whilst noting that, generally, there tends to be excessive focus on monitoring (33). In line with guidance (41, 43), research on Board effectiveness in healthcare and elsewhere suggest that a suitable agenda can be an effective means of ensuring that important strategic topics, such as quality and safety (Section 4.4.1), are afforded sufficient time and priority by the Board and, by extension, the organisation (23, 33, 141). Similarly, healthcare guidance describes how agendas might be developed in annual cycles, ensuring a suitable balance of topics over the course of the year (41, 43), a recommendation also made by research on high-performing non-healthcare organisations (141).

NHS guidance and regulation recommends that Boards operate in an open and transparent fashion (1, 46). Methods by which transparency with the public (transparency within the Board itself is referred to in Section 8.6) might be achieved include publishing strategic plans, annual reports, performance on key performance measures and by holding meetings in public (142). NHS Trusts, Primary Care Trusts and Strategic Health Authorities are required to allow members of the public to attend Board meetings, with the caveat that confidential matters may be discussed in private (91-93); Foundation Trusts are permitted to choose whether or not to hold their Board meetings in public

– something a survey of Board members suggests only a minority choose to do (143). The controversy has prompted debate over how best to balance openness with effective governance.

8.6 Culture and dynamics

As mentioned previously (Sections 4 and 5), while there are many important features that might support the effectiveness of a Board, effectiveness is not a tick-box exercise. Internal dynamics – personal interactions and relationships, as well as overall Board culture – are likely to play a significant part. The importance of board dynamics and culture is recognised in a range of guidance drawn from healthcare and non-healthcare domains, identifying Board members' conformance with the Nolan principles (61) and their display of such characteristics as openness – to new ideas and with one another – as key (8, 49, 60, 139, 144). In reviews of high-profile NHS failures, the Healthcare Commission identified Board dynamics as a causal factor, citing autocratic leadership styles and a 'culture of denial' at Board level (12, 13), a finding also reflected in a review of the evidence on failing healthcare organisations (139).

Guidance from healthcare and non-healthcare domains identifies 'corporate culture' – collective responsibility – as an important feature of an effective Board's approach to governance: responsibility is shared by executives and non-executives equally (1, 6-8, 10, 21, 27, 29, 41). The Policy Governance approach notes that the Board 'speaks with one voice or not at all', with 'total authority over the organisation and total accountability for it' (25). A study of NHS Board members presents a general view that Boards tend to operate cohesively, but notes that some Boards might operate with too high a level of trust (49). Further research in the NHS setting on leadership outlines an approach to analysing organisational culture that suggests strong associations with the nature of organisational performance (see Section 4.3) (68, 69).

Noting a failure on the part of guidance to identify key factors in Board dynamics, a review of Board members' behaviour highlights as important the character and personality of directors; the relationship between CEO and Chair, between CEO and Board, and between executive and non-executive directors (31). A review of corporate governance research on the Board director role identifies a challenge of balancing board cohesion against the risk of 'groupthink' (32). Corporate research indicates that Boards of 'high performing' healthcare organisations are characterised by their comparative openness, timely information sharing, transparent decision making and valuing all members' views equally.

A literature review on addressing problems in NHS organisations notes the importance of leadership, trust and open, constructive discussions at Board level, as well as the potential harm caused by 'groupthink' (139). Contact time is also thought to be important: for example, Chairs of 'low performing' healthcare organisations dedicate approximately a third of the time dedicated by Chairs of 'high performers' outside board meetings (94). A study of NHS

Chairs and CEOs reports that good communication, for example in agreeing responses to situations and negotiating roles and ways of working, is important to a successful relationship between these actors (96). Experience-based commentary emphasises strongly the importance of Board culture (62); much research, including reviews of the literature, is less confident, noting the likely importance of internal Board dynamics, but acknowledging that this factor is, as yet, not well understood (32, 33, 94).

9 Conclusions

This review was commissioned to support the development of *The Healthy NHS Board: principles for good governance*, new guidance for NHS Boards. By synthesising guidance and research drawn from healthcare and non-healthcare domains, covering both UK and international contexts, our review reflects a wide range of relevant perspectives on governance and how Boards lead and contribute to organisations. While the research presented is at times not conclusive, this reflects the complex nature of the relationships being studied. Further research will enhance our understanding of how these factors interact; examples of topics that might reward future study are discussed briefly below.

At the outset of this review, we attempted to define governance, referring to a number of models and theories. Governance – its purpose and mechanisms – remains a matter for debate, and not amenable to straightforward definition. However, there is much yet to be learned about how organisations function: how they relate to their wider context; why they succeed or fail. As we increase our understanding of how organisations work, it is likely that our concepts of effective governance will also evolve. An example of this is the growing recognition of the relationship between governance and organisational culture.

Much of this document has addressed the roles and contributions of Boards and their members. On this, a wealth of guidance exists, covering good practice in healthcare and other sectors. There are several examples of NHS guidance learning from private sector guidance: for example, *Governing the NHS* (1) refers frequently to the Higgs Review (7); and the *NHS Foundation Trust Code of Governance* (10) is based on the Financial Reporting Council's *Combined Code of Corporate Governance* (29). As noted in this review, a key feature of healthcare guidance is its stronger focus on the relationship between healthcare organisations and the wider society within which they operate.

Research suggests that guidance can make a difference: there are several examples of strong uptake of changes recommended in guidance, in terms of Board composition and processes. The relationship between such changes and improvements in Board effectiveness is not clearly evidenced, but our review indicates that there is probably no single 'best' way for Boards to govern effectively - although there is agreement on some of the key features of an effective Board, such as effective selection and induction processes, skilled and engaged members, well-structured agendas, timely and transparent information sharing, and regular evaluation. To improve our understanding of Board effectiveness, it is likely that we require a better understanding of Board culture and dynamics.

The increasing recognition of the Board's role in shaping organisational culture is of particular interest, but is as yet not well understood. Greater exploration of this issue – for example, the circumstances under which Boards can influence organisational culture in ways that may influence performance on such priorities as quality and safety or resource management – would be valuable.

As stated previously, this review has attempted to bring together a wide array of relevant perspectives on how Boards govern and add value to the organisations they lead. This has provided a valuable opportunity to learn more about the relationship between guidance and research in this domain. By feeding what we have learned into *The Healthy NHS Board: principles for good governance*, we hope to have contributed to the development of guidance that reflects and supports the valuable role played by Boards.

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