Engaging boards

The relationship between governance and leadership, and improving the quality and safety of patient care

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1 Introduction

One of the major consequences of the failures in quality of care and patient safety in the NHS, exposed by the public inquiries such as those relating to Bristol Royal Infirmary (Department of Health 2001) and Mid Staffordshire NHS Foundation Trust (Francis 2010), has been the Department of Health's initiatives to improve the governance and leadership performance of NHS boards

According to the NHS National Leadership Council's (2010) document *The Healthy NHS Board*, *where the NHS has failed patients on quality, too often a dysfunctional board has focused in the wrong areas and without the appropriate governance arrangements in place to improve quality*. In a similar vein, The Health Care Commission investigation into recent service failures identified a range of common factors that relate directly to the exercise of effective governance by NHS boards. These include:

> *a lack of responsibility from 'board to ward' for patient safety; an excessive focus on the meeting of centrally-set targets and delivering service reconfigurations at the expense of ensuring quality and safety; a lack of literacy and competency among directors in patient safety matters; the inability of chairs and other non-executives to hold executive directors accountable for the delivery of safe care; not having robust procedures in place to gather soft intelligence and hard data to make informed decisions about safety; and a failure to act proactively to identify risk to safe care, rather than responding only following an adverse event.*
>
> (Mannion 2011, p 3)

Worryingly, the same report went on to note that*:* 'The latest national survey of hospital trust boards in England undertaken by Dr Foster found that 9 per cent of hospital trusts do not discuss clinical outcomes and 10 per cent do not have patient safety as a constant item of the board agenda*.'*

While several publications expound good practice in relation to how boards should exercise their leadership and governance responsibilities, few are based on robust academic evidence of an association with organisational effectiveness. Indeed, the one common theme of researchers in the field is that there is a paucity of research evidence proving that boards do impact organisational performance, especially in relation to quality and safety of health care (Chambers 2011; Chambers *et al* 2011; Emslie 2007; Mannion 2011; Storey 2010). Moreover some studies conducted in health care organisations, including the NHS, that purport to have established evidence of a significant relationship between board performance and indicators of organisational effectiveness, raise questions as to their validity when scrutinised. Nonetheless, a few studies do appear to provide useful information for boards to consider how to improve their impact on health care outcomes.

Another source of valuable material for supporting boards is the research evidence from studies in organisational psychology, which have found a significant relationship between leadership and cultures of engagement, and organisational effectiveness. Some of these studies were conducted in the NHS. Such studies can be helpful in informing principles of leadership and

governance to be adopted by NHS boards in their strategic, and day-to-day, practice.

To address these issues, this paper focuses on two things:

- a review of the recent literature relating to the association between board activities and the performance of health care organisations, including the NHS, with particular reference to safety and quality of care
- an examination of the board's role in embedding a culture of safety and quality of care, and innovation, such that it is sustainable.

Practical recommendations as to how boards can become more effective in their leadership and governance role are either explicit in the discussion of research findings, or summarised in the tables.

2 NHS boards: Roles and responsibilities for leadership and governance

Numerous publications have described the purpose and role of NHS boards in relation to their governance responsibilities (eg, Bevington *et al* 2005a, 2005b; Cray 1994; Chambers and Higgins 2005; Chambers 2011; Institute of Directors 1996; NHS Confederation 2005). Among these, the National Leadership Council's (NLC) report (2010) *The Healthy NHS Board: Principles for good governance* provides an appendix identifying a range of models of governance, including agency, stakeholder, stewardship, policy, and generative. The NLC adds, however, that these models are not mutually exclusive. Thus, for example, aspects of the agency model, which emphasises monitoring and control systems, including performance measures and the use of sanctions and incentives, might be combined with aspects of a stakeholder model, which is concerned with engaging and balancing the needs of various stakeholders.

The document outlines the three key roles of a board, which are to: formulate strategy; ensure accountability; and shape culture. Alongside these are what it refers to as the three 'building blocks' of: context; intelligence; and engagement.

In the forward to the document, Sir David Nicholson, chief executive of the NHS in England, and Elisabeth Buggins (NLC board development lead) state that *boards must put quality at the heart of all they do … [by which is meant] patient safety, effectiveness of care and patient experience* (pp i). Indeed, this is the *sine qua non* of the service.

3 Board effectiveness and organisational effectiveness, including quality and safety: A review of the literature

Reviewing the literature on board effectiveness for the NHS Institute, Selim *et al* (2009) concluded that there is no 'silver bullet' with respect to a specific model for achieving board effectiveness in the NHS. This is unsurprising given that one of the most consistent themes in the research literature is the agreement among researchers that there is a paucity of evidence linking board performance to hospital performance (eg, Emslie 2007; Holland 2002; McDonagh 2006; Mannion 2011; Storey *et al* 2010), and specifically, the quality of care or patient safety (eg, Chambers *et al* 2011; Jha and Epstein 2010; Jiang *et al* 2009; Joshi and Hines 2006; Mannion 2011). Harvard Medical School researchers Jha and Epstein (2010) state that *little is known about whether or how boards are engaged in issues of clinical quality and if their activities influence care* (p 1).

Findings from US studies

A few US studies have reported a relationship between board practices and factors relating to quality of care.

Weiner *et al* (1997) found a positive relationship between the degree of engagement of boards in quality of care issues, and the likelihood of their hospitals having quality improvement programmes, but they did not examine the relationship with measures of quality of care.

Two further US studies did find a relationship between board engagement in quality activities and patient outcomes. The study by Joshi and Hines (2006), based on data from 30 US hospitals across 14 states, found a 'mild association' between board engagement in quality activities and hospital performance as assessed by measures of heart failure, heart attack, and pneumonia. The second study found an association between board practices relating to oversight of quality and lower mortality rates for six common medical conditions (Jiang *et al* 2008).

The third US study relates to the investigation of the engagement of hospital boards in quality-related issues and their performance in three clinical conditions: acute myocardial infarction, congestive heart failure, and pneumonia (Jha and Epstein 2010). Worryingly, less than half of the boards rated quality of care as one of their two top priorities, with only a minority reporting having received training in quality, less than half of the boards reporting they spent at least 20 per cent of their time devoted to discussing quality of care, and most boards primarily focusing on financial issues.

The researchers found large differences in the reported board activities between high-performing and low-performing hospitals, with the high-performing more likely to report:

- the board having expertise and/or have received training in quality of care
- clinical quality as one of the two top priorities for board oversight
- having a quality subcommittee

- using clinical quality as one of the top two priorities for evaluating CEO performance
- their board being influential in influencing quality of care
- their board being familiar with measures of quality used
- their board being familiar with their hospital's external ratings of performance on quality
- regularly reviewing a quality dashboard
- having established goals for improvement of care in relation to the four areas of: hospital-acquired infections, medication errors, external quality performance ratings, and patient satisfaction
- publicly disseminating these goals.

Only 20 per cent of chairs cited that they, or the board itself, or one of the board's committees, was one of the two most influential quality forces in their hospital. Chairs of high-performing hospitals were nearly four times as likely as those from low-performing hospitals to report that the board was influential. In contrast, 69 per cent of board chairs reported that the CEO was one of the two entities with the greatest influence on quality.

The authors acknowledge that a causal link cannot be assumed between boards' engagement in quality and hospital performance.

It is important to note that chairs of low-performing hospitals were likely to overrate the current performance of their hospital in relation to the national average. None of them reported that their performance was 'worse or much worse' than that of a typical US hospital, while 58 per cent reported their performance to be 'better or much better' (Jha and Epstein 2010). Given the evidence of a tendency for clear over-rating by some chairs (due to the 'social desirability' effect) it is perhaps even more disturbing that the researchers report that *approximately half of the boards did not rate quality of care as a top priority for board oversight, or for CEO performance evaluation* (p 7); ie, the reality might be even worse.

Such findings suggest caution in accepting the reliability and validity of self-reported data of performance effectiveness, including that of boards.

While of interest, UK researchers have advised against assuming that findings from US studies can be extrapolated to the NHS. Mannion (2011) offers two reasons why there might be differences: differences in the political and economic environments impact on the priorities and objectives of boards, and most of the studies conducted have involved large-scale surveys which fail to *capture fully the messy internal processes and behavioural dynamics through which board governance is actually played out and which are best explored through more interpretive and qualitative research designs* (p 2).

Although several studies in the corporate world have found a statistically significant relationship between corporate governance and organisational performance (eg, Aggarwal and Willliamson 2006; Cheung *et al* 2007; Hermes 2005), again none has proved a significant causal relationship.

There is, potentially, a multitude of reasons why a direct *causal* link has not been established between board effectiveness and quality of care, not least of which is that no longitudinal studies have been published. Additional

reasons suggested by researchers, include: the relationship is complex and non-linear; the impact of the board might only be evident in times of crisis or major change; and the effect of the chief executive's role encompassing both that of governance and of leadership moderates the relationship (Sofaer *et al* 1991). Furthermore, as Lockhart (2006) points out, the entire process of management, together with the organisation's internal processes, plus factors in the external environment at sector and societal level have an effect on the relationship between board governance and organisational performance.

Other mediating and moderating variables include: the specific challenges facing the organisation; the relationship between the chair and the chief executive (see below); the various cultures and subcultures within an organisation (eg, Davies *et al* 2000; Gerowitz *et al* 1996; Mannion *et al* 2005; Lok *et al* 2011); and the role and influence of relevant external agencies, including central government agencies, professional bodies, and trade unions.

An exploratory investigation of NHS board effectiveness

The NHS Confederation (2005), seeking to stimulate debate in the area of board effectiveness, undertook an exploratory study of 12 NHS boards selected randomly from a range of trusts. Qualitative data were gathered via observations of one board meeting per trust, and interviews with board members in relation to their notions of the characteristics of an effective board, and the 'reality' based on their experience.

Four themes emerged in relation to the characteristics of effective boards:

- a focus on strategic decision-making, rather than on operational issues
- trust among board members, and acting cohesively/behaving corporately (in some boards, there was 'arguably too high a level of trust')
- constructive challenge among the board members ('board members rarely challenged each other in public meetings, and stuck to their functional responsibility')
- chairs ensured that meetings had a clear and effective purpose, and appropriate decisions were taken (some agenda items were unclear, as was the action required. Often papers were long, detailed and lacked clarity of purpose).

This study illustrates the disparity between individuals' espoused theories of action, and their 'theory-in-use' (Argyris and Schön 1974), and contributes to a potentially richer understanding of the complex nature of board effectiveness. It also illustrates the complexity of measuring the behaviour of boards as an independent variable when attempting to analyse the association with outcome, or 'criterion' variables, of board effectiveness in terms of impacting quality of care – often referred to as 'the black box' problem in social science (LeBlanc and Schwartz 2004).

At a more prosaic level, it emphasises the potential benefits to chairs, and their boards, of strengthening their skills in running effective meetings.

Study one: The association between the performance of boards of foundation trusts and trust performance

This study (Emslie 2007) involved a sample of 79 board members representing 21 foundation trusts who rated board performance using the *Board Self-Assessment Questionnaire (BSAQ).* Organisational performance was based on Monitor's financial performance ratings; use of resources, patient care, and national staff survey data from the Healthcare Commission; Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster; and clinical productivity indicators provided by the NHS Institute for Innovation and Improvement.

There was a strong positive correlation between the 'strategic' dimension of the *BSAQ* and financial performance, and also between ratings on the 'political' dimension of the *BSAQ* and a range of staff satisfaction measures. Interestingly, there was no significant correlation between Monitor's financial risk rating and the Healthcare Commission's use of resources, nor between HSMR ratings and the boards' self-ratings of performance. Neither were correlations found between the boards' rating of their performance and patient care data, nor clinical productivity indicators.

The use of the label 'political' for the particular *BSAQ* scale referred to appears somewhat misleading, since among the items are those relating to inclusion of staff in decision-making, and a sensitivity to the needs of staff and the community, which can be regarded as antecedents of a culture of engagement (Alimo-Metcalfe and Alban-Metcalfe 2008).

The validity of boards' self-ratings of effectiveness is an important issue, which is discussed below.

Relationships between board members – including between the chair and chief executive

Evidence as to impact of the quality and nature of the relationship between the chair and the chief executive on the performance of the board is weak, both within the NHS (Exworthy and Robinson 2001), and in the wider public sector (Office for Public Management 2009), and also in the private sector (Dalton *et al* 1998; Kakabadse 2006).

Dalton and colleagues identified two major issues affecting boardroom performance as: power imbalance resulting from board composition, and the nature of the CEO and chair role in chairing meetings (see Singh *et al* 2001). This appears to corroborate the findings of a study conducted in the NHS by Storey *et al* (2010), described below.

The need to balance personal trust among members of the board with the appropriate use of constructive challenge is a characteristic that emerges regularly in the wider literature on effective board behaviours (eg, Chambers and Carnforth 2010; Wong 2011; Nadler 2004; Sonnenfeld 2002).

NHS boards and organisational performance

Three academic studies conducted in the NHS, two of which gathered data on quality of care as rated by patients, have found a significant relationship

Study two: The intended and unintended outcomes of new governance arrangements within the NHS

This study (Storey *et a*l 2010) gathered qualitative data via case studies from a range of trusts (n=14), and interviews with members of trust boards; quantitative data (national surveys of board members of acute/ foundation trusts and PCTs in England); and performance measures. The principal significant finding was that there was a significant relationship between trust board governance and financial and other business measures, which, in part, reflects the findings from the previous study.

A US study described below also found a relationship between hospital governance and financial performance measures of a sample of US hospitals, however the methodology raises serious questions relating to its validity (discussed below).

This NHS study, in common with that of Emslie (2007) did not reveal a significant relationship with clinical outcomes, such as quality and patient care. The researchers add that:

> *…both executive and non-executive directors were far less confident in attending to clinical issues than they were with respect to the use of financial resources. It might be hypothesised that, as trust board governance matures and as the focus increasingly turns to matters of quality and safety, trust board governance may also extend its reach into clinical areas and that positive impacts may in future be measured more clearly.*
>
> (Storey *et al*, p 5)

This has yet to be tested.

The influence of the board on the behaviour of clinicians and other individuals involved in delivering patient care is somewhat more complex than managing financial resources, since the former involves influencing the culture of a trust. This is one of the core roles of NHS boards, and is explored in more detail in a later section.

Another important finding from the Storey *et al* study highlights a factor that might help contribute to an understanding of the 'black box' question regarding board effectiveness, including the behaviour of the chief executive and their effect on the dynamics within the board. Storey and colleagues found that 'overly assertive or domineering' behaviour of the chief executive was judged negatively by board members, and more importantly that there was a *significant negative relationship between high ratings of chief executive assertiveness and performance measures on a whole range of variables* (p 4). (One obvious question is whether assertiveness is a euphemism for aggression or bullying). The NHS Confederation report (2005) confirms the dysfunctional effect of such behaviours on board effectiveness, and as mentioned above is consistent with evidence from the corporate world.

Study three: A study of boards of high-performing organisations in the NHS

This study (Chambers *et al* 2011) is particularly valuable because of the methodology adopted in identifying the 19 top performing NHS organisations (specialist, acute, mental health, primary care). As with Emslie's study, data were gathered from three key perspectives, namely those of patients, employees, and 'the business' (see below), to determine performance.

Performance data*:* Data from the perspective of patients were gathered from the National Patient Survey Programme in relation to:

- access and waiting time
- safety, and quality of co-ordinated care
- information and choice
- building closer relationships
- cleanliness, comfort, friendliness.

Performance data, based on assessments by employees of their trust, came from two components of the annual NHS Staff Survey, 'job satisfaction', and 'staff recommending their trust as an organisation in which to work'. The third element, the business performance rating, came from the Care Quality Commission's annual performance ratings, which include both quality and financial management.

'High performing organisations' were those trusts which consistently scored high according to national norms, over at least a few years, on two or all of the three areas rated. A random sample of 'non-high performing' trusts was selected from those not rated highly. This reflected the same distribution of type of organisation.

Board data*:* These included: the size of the board; the tenure of the current chief executive; gender composition, and non-executive director (NED) contributions to board meetings reflected in the minutes. Although, owing to the small numbers involved, the results did not reach statistical significance, the findings indicated that high-performing trusts were more likely to:

- have a chief executive who had been in post for at least four years
- have a higher proportion of women on the board
- have NEDs who actively contributed to the board agenda
- be a specialist/tertiary trust.

between certain characteristics of NHS boards and organisational performance.

Gender composition of the board

The Chambers *et al* study, which represents one of the first conducted in the NHS to show a relationship between gender diversity and the effectiveness of boards (Chambers *et al* 2011, p 6), corroborates evidence from the private

sector, which indicates that the greater representation of women on the boards of companies is strongly associated with company performance (eg, Bilimoria 2000; Catalyst 2004; European Commission 2010; McKinsey 2010; Singh *et al* 2001). Although a causal relationship has not been established, at least two studies have found that the presence of more women on company boards appears to impact positively on board decision-making, 'more civilised behaviour', and sensitivity to other perspectives (Terjesen *et al* 2009, p 329), greater transparency and a higher quality of governance (Brown *et al* 2002; Singh and Vinnicombe 2004).

Contribution of non-executives

The active contribution of non-executives to board discussions emerged as one of the three key elements of effective board dynamics in a review of the literature (Chambers and Cornforth 2010). The other two were: high trust between board colleagues (which reflects the findings for the NHS Confederation study of 2005, described above); and high levels of engagement between board members, in and out of board meetings.

Need for academic rigour

The academic rigour of studies that assert they have identified a statistically significant relationship between board effectiveness and quality and safety of patient care should be scrutinised carefully, given their potential influence in informing board development, recruitment, and other recommendations.

A fundamental challenge to increasing board effectiveness, and to conducting research on the association between board performance and organisational performance, are the questions: what are the appropriate aspects of board performance on which to focus as independent variables? (eg, Chait *et al* 2005; Herman and Renz 1997; Holland 2002); and what are the most reliable and valid sources of ratings of board performance?

How valid are board self-assessments of effectiveness?

The methodology adopted by some studies that purport to provide evidence of a significant association between board activity performance and the organisation's performance, raises questions as to the validity of the data gathered, and, therefore, of the findings.

For example, a frequently-cited US study investigating the association between board competencies and the performance of non-profit hospitals (McDonagh 2006), gathered data on the effectiveness of boards using the *Board Self-Assessment Questionnaire (BSAQ),* referred to earlier. Leaving aside the fact that the validity of self-report data is regarded generally as of questionable reliability and validity (eg, Fleenor *et al* 2010; Podsakoff and Organ 1986), the individual who rated the performance of the hospital boards in this particular study was, in most instances, the CEO of the hospital. The response rate from board members was 13 per cent, with two-thirds of CEOs not allowing the members of their board to complete the assessment. As the author commented: *After reviewing our survey tool, many CEOs might have been concerned about asking board members some of the detailed and sensitive questions about their own performance on the board* (p 382).

Given the unrepresentative sample and the obvious potential for bias in the data, it would seem injudicious to be influenced by the conclusions of the study, namely that there was a strong correlation between the effectiveness of boards and hospital profitability, and lower expenses 'per adjusted discharge' (McDonagh 2006).

How should board effectiveness be measured?

Given the unsurprising finding that board self-assessments appear unreliable then it follows that data gathered from a range of other sources, for example, through 360 processes, should be considered.

Evidence of a disparity in the perceptions of a board's governance and leadership effectiveness, from the perspective of board members versus senior managers immediately below the board, is emerging in a study in progress in the NHS (Alimo-Metcalfe and Bradley in progress). Board performance data have been collected from the use of *The Board 360™ (B360™)* which was completed anonymously by all board members in three NHS trusts, and by groups of raters (internal and external stakeholders of the trusts). The instrument includes a combination of board competencies, identified from a literature review, and dimensions relating to a model of engaging leadership behaviours. This model emerged from a three-year investigation of leadership in the NHS and local government. This model has been validated in a longitudinal study of the effect of an engaging leadership culture in predicting team productivity, morale and wellbeing in a sample of multi-professional teams in the NHS (Alimo-Metcalfe *et al* 2007, 2008).

Analyses of the *B360*™ data have yielded significant differences between the groups of raters in relation to rating an extensive range of board leadership competencies and behaviours. In most instances the boards' self-ratings are higher, which is consistent with findings from the research literature on 360/multi-rater feedback in relation to individuals' self-ratings (Alimo-Metcalfe 1998; Atwater *et al* 1998; Fleenor *et al* 2010 and studies cited earlier).

Given that leadership effectiveness is about the impact on others, it can be argued that, at least in relation to those questions that refer to behaviours and activities that can be observed by relevant others, their perceptions should also be gathered.

The *B360*™ instrument used in this study also contains impact measures which gather data on the impact of the behaviour and culture of the board on the job satisfaction, motivation, commitment, discretionary effort, sense of fulfilment, morale, and wellbeing of its members. These are closely related to measures of engagement. Senior managers rating the board on its effectiveness also rate the impact it has on themselves, in relation to eight of the nine impact measures. The use of the impact measures serve to test whether the dimensions assess relevant behaviours of leadership, and, therefore, if the instrument is valid. Early results are showing that the dimensions of board leadership assessed by the instrument have a significant impact on both the boards' and the senior managers' engagement and wellbeing, and that the dimensions have different patterns in predicting the various impact measures (Alimo-Metcalfe and Bradley ongoing).

One of the factors that affects the effectiveness of a board is the morale and wellbeing of its members (Chait *et al* 2005). Board members are members of a team, and there is substantial research to show that the morale of a team,

and its levels of engagement and collective team identification, significantly predict their effectiveness (eg, Day *et al* 2004; Gully *et al* 2002; Yun *et al* 2007).

The implications for research and development

These findings have five major implications for the development of boards, the recommendations as to how boards should enact their leadership and governance role, and for the methodology adopted in conducting research on board effectiveness:

Implications of the findings for research on board effectiveness

- They provide evidence that self-ratings by board members of their leadership and governance effectiveness tend to 'be inflated' in relation to the ratings of other relevant stakeholders, in particular, senior managers.
- Board members' perceptions of their effectiveness significantly impact their engagement and wellbeing.
- Senior managers' ratings of their board's effectiveness significantly impact their engagement and wellbeing.
- These data suggest that one of the potential reasons for a paucity of evidence of the impact of the boards of NHS, and other health care organisations, on the performance of the organisation, including quality and patient safety, might be because the current measures of the independent variables (ie, board self-ratings of board effectiveness) are invalid, and that the ratings of other relevant stakeholders, including senior managers, should be adopted.
- The dimensions on which board leadership and governance effectiveness are being measured lack construct and content validity, that is the important dimensions are not being assessed.

Implications for board development

- Boards should seek feedback (ideally 360-feedback rated anonymously) on their effectiveness from a range of relevant internal and external stakeholders, including, importantly, senior managers in their organisation.
- Boards should identify the impact of how they work as a board, on their degree of engagement, morale and wellbeing.
- Boards should identify the impact of how they work as a board, in relation to the degree of engagement, morale and wellbeing, of a range of relevant internal stakeholder groups, including senior managers in their organisation, and, possibly, relevant external stakeholder groups.
- Boards should be supported in using the data from (360) feedback, to enable them to work more effectively as a board.

- Boards should be supported in identifying how best to respond to the feedback from those who have rated them, and how to improve their effectiveness.

The next section discusses the critical role the board has in modelling the appropriate leadership style to create a culture that will ultimately affect the quality and safety of care for patients and offers practical recommendations for supporting board effectiveness.

4 Board leadership and organisational culture

The research described above has focused on studies that have investigated the direct association between board effectiveness and organisational performance measures, including quality of care, and one can only conclude that the evidence is weak. Reasons for this have also been suggested, to which can be added the fact that none of the studies has taken account of the mediating effect of organisational culture.

Governance is enacted through leadership, which, in turn, impacts on the culture of an organisation. Indeed, Schein (1992) asserted that *leadership and culture are two sides of the same coin*. Organisational culture is often described as 'the ways we do things around here'; it is *the values and practices that are shared across groups* in an organisation (Kotter and Heskett 1992) and articulated in the behaviours of its members. The creation of the appropriate culture is the key responsibility of those in a leadership role (Kotter and Heskett 1992; Schein 1992). For the NHS, it is the thread that links board discussions and decisions from the top through every level, to the patient (the principle of 'board to the ward' responsibility, and indeed reciprocated by 'from ward to board responsibilities of directors') (Machell *et al* 2009).

In attempting to improve quality, the Department of Health has placed 'levers and incentives to improve quality ..[by] linking the payment system more closely with patients' experiences, as well as strengthening the regulatory system to safeguard quality and safety' (National Leadership Council 2010, p i). But, while such systems and incentives might affect the decisions of the board and senior managers, they may not have any beneficial effect on creating the kind of culture that will promote the behaviours enacted by staff with patients that produce high-quality, safe care. Indeed, such systems, with their associated performance targets, have been found to have unintended consequences which include producing the opposite effect to that intended (eg, Francis 2010; Storey 2010).

In her thought piece Elisabeth Buggins (2011) states that the culture of the NHS is one in which *an undercurrent of anxiety is endemic* (p 2), citing the Francis report (2010) which found that a *shame and blame culture of fear appears to pervade the NHS and at least certain elements of the DH*. The latter reference to the Department of Health is important to note, since managers under pressure to deliver on targets typically default to a command and control style, become insensitive and defensive, and stifle the very behaviours that are being encouraged to improve the quality and safety of care.

As to the nature of the culture required by the NHS, two recent reports make it clear. *The Healthy NHS Board,* referred to earlier, identifies 'engagement' as one of the three critical building blocks to 'shaping the right culture'. In a more recent report, Innovation, Health and Wealth (Department of Health 2011), Sir David Nicholson describes the need for a 'major shift in culture': *Searching for and applying innovative approaches to delivering healthcare must be an integral part of the way the NHS does business. Doing this consistently and comprehensively will dramatically improve the quality of care and services for patients. It will deliver the productivity savings we need to meet the growing demand for services* (p 5). The same report

states that this must start with the board, who will also be accountable for its achievement, and, importantly, that the approach to 'leadership for innovation' from the board should be that of an 'empowering board', responsible for 'liberating' NHS staff to be innovative.

The board's role in fostering a culture of engagement

The nature of the hospital culture, then, is the ultimate test of any board whose business is to ensure that quality is at the heart of all it does. This can only be achieved if the board ensures that:

- it models the appropriate leadership behaviours in the manner in which members behave towards each other
- board members adopt these behaviours in every relationship with other internal, and external stakeholders, from patients and their families, through to staff throughout the trust, and with external partners
- the board communicates to all staff in the organisation the importance and responsibility of adopting an engaging style of leadership, and one which encourages innovation, with all with whom they work, and encounter in the course of their work
- the board is informed of how the culture of the organisation is being experienced by staff, patients and their families, and other key stakeholders, in relation to engagement and innovation, and takes appropriate action, where needed.

In terms of creating a culture of empowerment, engagement, and innovation, it is important to identify two dimensions of leadership behaviour to be exhibited by the board, namely the content and nature of *what* the board does – both during board meetings and when interacting with others; and *how* the board performs these aspects of its role. The 'what' of board functioning includes: discussion of quality; discussion of innovation, adoption, and spread in terms of best practice in clinical and patient care; clarity and accountability; constructive challenge; and effective performance and risk management. The 'how' includes: engaging as an effective team and engaging, listening to, consulting, and positively influencing internal and external stakeholders (Alban-Metcalfe and Bradley 2012).

Buggins (2011) makes a range of practical suggestions about what the NHS, including its boards, should do to promote high levels of engagement. These include:

- paying more attention to the importance of staff engagement
- staff engagement and satisfaction scores should be a core component of performance assessment of individual in leadership roles and ratings of organisational success, and these data should be made visible to the public. (I would also add that boards should review these data, at a minimum, annually)
- boards and leaders at all levels should model the behaviour they wish staff to deploy with patients and those who fail to behave in a manner commensurate with the agreed values of their organisation, or of the NHS Constitution, should be held to account

- a set of standards measuring patients' experiences should be developed, supported by measurable indicators. (I would also add that the board should regularly review these)
- Healthwatch must be sufficiently resourced and recognised to provide a safety valve for patients and relatives, and to engage with the NHS in developing a clear picture of the patients' views of responsiveness and quality of care provided. Connections with foundation trust governors would assist in holding trust boards to account.

Buggins extols NHS managers and organisations to place 'as much attention to staff engagement as target delivery' (Buggins 2011).

The board's role in ensuring quality, safety, and innovation

The role of the board in ensuring patient safety and quality of care, then, is principally two-fold. First, to ensure that the way in which the board operates is such that: (a) due time be spent on issues such as quality issues and patients' safety (which should be on the agenda of every meeting, and significant time devoted to discussion) and on discussion of progress in relation to initiatives that fall within the remit of 'innovation' and the adoption and spread of best practice, ie, the *what* of board activity; and (b) all board members are treated with respect, with zero tolerance of 'over-assertive' behaviour, ie, the *how* of board activity. The other is to recognise that the board cannot act directly on all aspects of safety and quality. It must act through the agency of staff at all levels, which means that it must foster a culture of engagement which includes due regard to the physical health and wellbeing of staff.

There are sound evidence-based reasons for promoting a culture of engagement, and the paper by West and Dawson (2012) in this series describes many of these. However, there are two additional reasons that are worth emphasising.

Stress and quality of care

Having to deal with constant change in the public sector has been identified by Valle (1999) as resulting in increased levels of stress and decreased sense of personal satisfaction among health care staff. In the current economic climate, which has raised the additional fear of job security, people who would otherwise take a break from their job to alleviate their stress may be too anxious to do so, with the result that they become even less effective in coping with work. Not only is this likely to affect their relationships with colleagues, and perhaps their wellbeing, but if they are working with patients it is likely to result in reduced quality of care, and possibly safety. The Boorman review (2009a, 2009b) which investigated the mental health of NHS staff found a significant *negative* correlation between levels of stress in NHS and trust performance, as rated by the Audit Commission. Of the staff interviewed for the study, 80 per cent of those who were in daily contact with patients admitted that their levels of anxiety, stress, and depression influenced the quality of care they gave. This is consistent with several studies that have investigated the effect of stress on nurses (eg, Abu Al Rub 2004; Jennings 2008), doctors (eg, Firth-Cozens and Greenhalgh 1997), and allied health professionals (eg, Painter *et al* 2003).

There is research evidence that stress reduces higher order thinking, including problem-solving, creativity, and decision-making (Svensen and Maule 1993). Rather than being able to think more innovatively, individuals under stress typically exhibit a narrowing of focus and a stereotyped response (Mandler 1984).

US professor Christina Maslach, a prolific researcher in the field of burnout (the state of extreme levels of stress) maintains that burnout and engagement are bi-polar opposites (Maslach 2011; Maslach and Leiter 2008).

To perform their role properly, boards must be sensitive to the context in which staff operate, use both 'soft' intelligence, as well as 'hard' data, and strive actively to promote a culture of engagement (National Leadership Council 2010), and one that protects employees' wellbeing.

Innovation and readiness for change

Since boards are to be judged on the extent to which they ensure a culture of innovation in their organisation, with the intention of spreading best practice in quality of care, then they must adopt an approach to leadership that creates cultures with high levels of 'readiness for change'.

Readiness for change (RfC) can be defined as *the extent to which employees hold positive views about the need for change (ie, change acceptance), as well as the extent to which employees believe that such changes are likely to have positive implications for themselves and the wider organisation* (Jones *et al* 2005). It has been found to be a significant mediator of the relationship between change strategies and success of change initiatives.

Within the health care sector, a Canadian study investigating what predicted RfC in a large general hospital (Cunningham *et al* 2002) found that RfC was increased where:

- staff perceived their jobs to be challenging, but they also felt empowered to manage them
- staff had a high level of autonomy
- there were high levels of social support
- an active approach to problem-solving was encouraged
- individuals were supported in experiencing high levels of 'job change self-efficacy', ie, confidence in their ability to cope with change.

These findings are highly consistent with those obtained from a three-year longitudinal study undertaken by King's College and Real World Group, funded by the NHS Service Delivery Organisation, investigating the impact of leadership on the effective handling of complex change in the NHS (Alimo-Metcalfe *et al* 2007, 2008). It found a causal relationship between the degree to which the culture of a team (multiprofessional crisis resolution teams working in the field of mental health), was rated as high in 'engaging leadership', and the productivity of the team one year later. Contextual variables, such as case load and resources available to the team were controlled for. Importantly, high-performing teams were also found to have high levels of morale and wellbeing. This is one of the few published studies

to provide evidence of a significant predictive relationship between a culture of engaging leadership and productivity.

The culture of highly productive teams was characterised by the following:

- staff felt involved in developing the vision
- staff felt involved in determining how to achieve the vision
- staff felt empowered by being trusted to take decisions
- staff felt actively supported in developing their strengths
- staff believed their ideas would be listened to
- time was made for staff to discuss problems and issues, despite the busy schedule
- there was high use of face-to-face communication.

Working in an Australian state government department, Jones *et al* (2005) found that high RfC was associated with employees perceiving the culture as reflecting strong human relations values, and as having high 're-shaping capabilities'. The latter is the ability to renew competences to achieve congruence with the changing environment. Strength of re-shaping capabilities is strongly correlated with rates of implementation success.

On the basis of these data, it is evident that a culture of engagement is of critical importance in the NHS. In particular, it is relevant in relation to:

- ensuring that safety and quality are 'hardwired' in the behaviour of NHS staff, coupled with enabling staff to cope with high levels of stress, without reducing morale and wellbeing
- creating a culture of 'readiness for change' (RfC), purposeful innovation (rather than innovation for its own sake), and constant improvement
- working most effectively with other stakeholders in the wider community
- having boards that conduct their behaviour in such a way as to promote engagement among themselves, and throughout the trust.

What are the behaviours of engaging leadership?

A three-year investigation of the behaviour of engaging leadership in the NHS was undertaken by the University of Leeds (Alimo-Metcalfe and Alban-Metcalfe 2001). It was conducted in parallel in local government, and has since been validated in other organisations in the public and private sector (Alban-Metcalfe and Alimo-Metcalfe 2007; Alimo-Metcalfe and Alban-Metcalfe 2001; Dobby *et al* 2004; Kelly *et al* 2006).

The model is described in Figure 1. It includes four clusters of behaviour which relate to personal qualities and values, engaging individuals, engaging the team/organisation, and engaging various stakeholders. There are several peer reviewed articles providing evidence of its validity in impacting the morale, wellbeing, and aspects of engagement of staff (eg Alban-Metcalfe and Alimo-Metcalfe 2000a, 2000b; Dobby *et al* 2004; Kelly *et al* 2006).

Figure 1: The structure of the model of 'engaging leadership'

Personal qualities and values
Being honest and consistent
Acting with integrity

Engaging with individuals
Showing genuine concern
Being accessible
Enabling
Encouraging questioning

Engaging the team/organisation
Supporting a developmental culture
Inspiring others
Focusing team effort
Being decisive; risk-taking

Engaging stakeholders (moving forward together)
Building shared vision
Networking
Resolving complex problems
Facilitating change sensitively

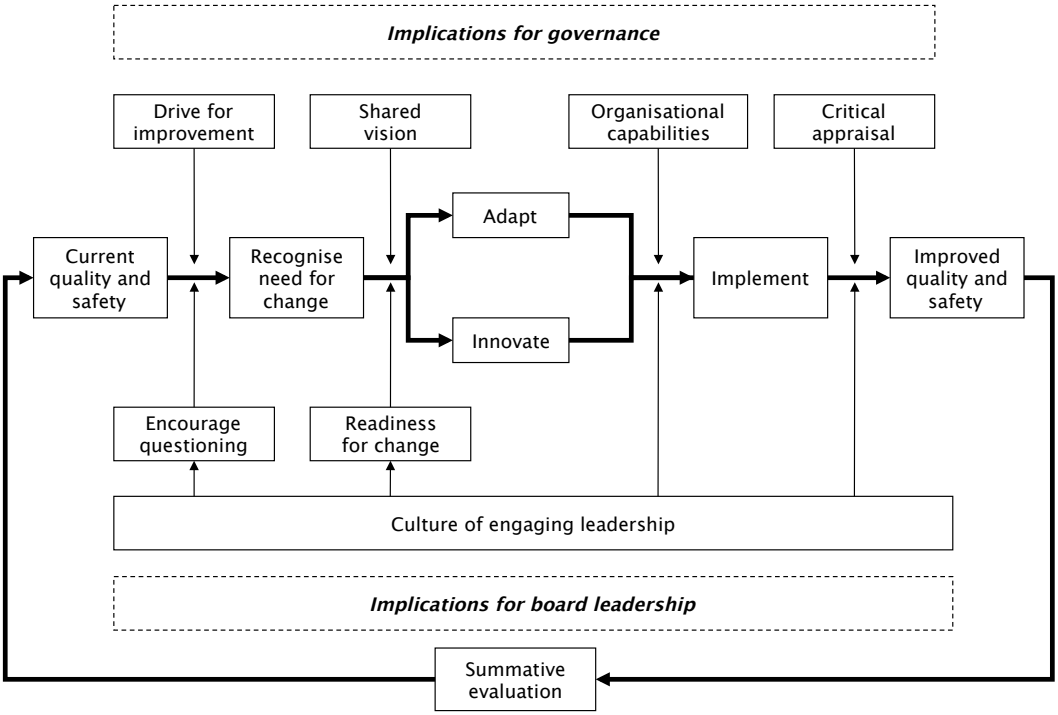
The model of engaging leadership, and in particular the cluster labelled 'Engaging individuals', includes behaviours which are highly similar to those it is suggested, managers should adopt to transform the culture of the NHS. These include paying more attention to staff, listening to them, enabling them to feel valued and to express their concerns, and to 'focus on creating meaning through engaging and harnessing the ideas and goodwill of staff, while providing an environment of care coherent with their aspirations and values' (Buggins 2011, p 4).

Interestingly, these behaviours also echo the views of service users of adult mental health services and their carers about what they believe high-quality care to be (Alimo-Metcalfe *et al* ongoing; Locker *et al* 2011).

Boards gathering data on how the culture is perceived by staff

In order for boards to be assured that a culture of engagement is embedded in their organisation, NHS organisations should undertake, at least bi-annually, a cultural diagnosis to identify how the culture is perceived by staff across the organisation, in relation to aspects of engagement and readiness for change. Data on the impact of culture should also be gathered, and/or these data could be related to staff survey data. This would not only provide data to the board on the extent to which engagement is experienced at all levels and across various departments, but would also provide valuable data for trust staff involved in organisational development, enabling them to identify where they might usefully intervene to strengthen the culture, and in which specific aspects of engagement and innovation. Where there are areas in which engagement and a culture of innovation is strong, organisational development staff could explore how this could be used as a wider resource for the trust. More details of the process for such activities, and case studies have been published (Alimo-Metcalfe and Alban-Metcalfe 2011).

Figure 2: Quality and safety improvement cycle



The relationship between board effectiveness, cultures of engagement, and high readiness for change, and improving quality and safety of patient care outcomes

Figure 2 seeks to summarise the implications for board governance and leadership within the quality and safety improvement cycle, with particular reference to a drive for improvement in quality; shared vision; organisational capability; and critical appraisal, or scrutiny.

It seeks to bring together the governance responsibilities of an NHS board, and the leadership role in shaping the culture of engagement and innovation. In relation to leadership, the impact of engaging leadership is direct – on the extent to which adaptations and innovations are implemented effectively, and lead to improvements in quality and safety, and indirect – through empowering staff and the encouragement of questioning which challenges the *status quo*, and activities in relation to scanning for, and adopting and spreading, innovative best practice.

The intention of creating a culture of engagement which supports the conditions for readiness for change is to increase motivation, morale, self-confidence, proactivity, and wellbeing of staff, such that improving quality and safety of patient care is intrinsic to 'the ways things are done'.

A series of recommendations for action are included on page 25.

5 Concluding thoughts

In spite of various studies that have been undertaken in the UK and US to investigate the impact of the board on the performance of health care organisations, and particularly quality and safety outcome measures, the evidence can at best be described as weak. Three US studies have found an association between boards that place a great deal of attention on regularly reviewing hard data on quality issues, and clinical outcomes. While, of course, these findings can be regarded as useful indicators of correlates of board activity and clinical outcomes, it cannot be concluded that the relationship is causal since none of the investigations were longitudinal. In addition, it cannot be assumed that other factors, such as the mediating effect of the culture and leadership of the organisation, did not contribute to the findings. Indeed, it would appear fatuous to disregard such variables, particularly in the light of evidence obtained within the NHS that the quality of leadership of teams significantly predicts their performance in relation to quality of care provided.

Given the substantial challenges facing the NHS over the next few years, the board's role and responsibilities become of supreme importance in shaping a culture which – through the action of staff – supports the delivery of high-quality, safe care. This culture should promote innovation, improvement, and quality, by ensuring high levels of staff engagement and wellbeing.

6 Additional practical recommendations for the board

Quality

Patient safety, clinical effectiveness, patient experience

Strategic activities

- Ensure that quality is a major agenda item for every board meeting and that the discussion is substantial (preferably early in the meeting, rather than towards the end), and informed by appropriate soft as well as hard data.
- Ensure that all board members have a thorough understanding of patient safety, and are familiar with the measures of quality used, and with external ratings of trust performance.
- If necessary, provide training in quality, to increase board members' confidence.
- Regularly review a quality dashboard, and external ratings of performance
- Agree a set of standards for measuring patients' experiences and measurable indicators; patient-reported outcome measures should be regularly reviewed; trust boards should be held to account for achieving and maintaining high standards of care (*see* Buggins 2011).
- Regularly review quality improvement programmes/initiatives; invite those responsible to present to the board on progress, learning, achievements and dissemination activities; publicly recognise efforts and achievements.
- Consult relevant internal stakeholders, including clinicians and other staff, and relevant external stakeholders, before developing strategy.
- Inclusion of patient safety data, such as clinical outcomes, should be a constant item on board agenda:
  - establish goals for improvement of care
  - publicly disseminate these goals.
- Include discussion of quality in chief executive's appraisal (*see* Buggins 2011).
- Ensure that activities do not create a 'shame and blame' culture, but rather support a culture of transparency, collaboration, learning and improvement.

Other on-going activities

- Encourage board members to 'get out and about' in the organisation, to listen to patients and staff, and to get a feel for how care is being delivered, and the environment in which staff are working.

- Invite patients to board meetings to describe their experiences of care in the organisation (positive and negative); and create opportunities to talk to patients while they are in the trust.
- Board members should be encouraged to visit areas in the organisation where:
  - efforts are being made to improve quality, to support staff
  - initiatives have been successful.
- Consider board members becoming 'champions' for a specific project, so as to raise the project's profile, signal board support, and increase board members' understanding of clinical and organisational issues.
- The board should model best practice by reviewing the contribution it has made to improve quality by reflecting, at the end of each meeting, on 'What have we done to improve a culture of quality, innovation, and engagement and learning in the trust?'

Innovation

Searching for and applying innovative approaches to delivering healthcare

(Department of Health 2011)

Strategic activities

- Regularly review the topic of the innovation – that is, the adoption and spread of best practice – and activities within the organisation at board meetings.
- Create regular opportunities for presentations to the board by staff working on particular improvement or change projects, so that board members can support their efforts, learn about difficulties encountered, acknowledge achievements, celebrate their success, and propose methods of dissemination.
- Board members should be familiar with local health innovation and education cluster (HIEC) activities and case studies, and discuss how their organisation might benefit from these.

Other on-going activities

- Boards as a whole, and board members as individuals, might consider ways in which they can champion, or provide a means of raising the profile, and/or success of local innovations, perhaps by supporting an event that celebrates such achievements, and by encouraging publications by the staff involved.
- Events, such as 'marketplace', Dragons' Den, World Café, and Open Space, should be supported by the board to encourage the generation, and recognition, of ideas, innovations, improvement initiatives, etc, and board members should attend them whenever possible. The board may decide to create way of recognising or rewarding efforts, or seek suggestions from staff.

Intra-board processes

Working effectively together

Strategic activities

- The roles of the chair, chief executive, executive directors and non-executive directors should be clear.
- Chairs should ensure that meetings have clear agenda, each item having a specific purpose and intended outcome (eg, a decision, or agreed course of action); board papers should be short and succinct.
- Board involvement should focus on strategic issues for the organisation, and support, but not interfere with, operational matters.
- The chair's role is to encourage the engagement of all board members (irrespective of functional responsibility) in robust, constructive discussion, and challenge, where appropriate.
- If necessary, the chair should take steps to increase the confidence of board members when discussing relevant clinical issues.
- Mutual trust and collaborative working among board members should not deter constructive challenge.
- The chair should not dominate discussion, or allow any board member, including the chief executive, to behave in a way that is disrespectful and/or inhibits the contribution of others; there should be a zero-tolerance of overly-assertive or bullying behaviour.
- All board members should model the leadership style of 'engaging with others', and be clear of the distinction between the 'what' of its leadership responsibilities (to be competent in performing their role), and the 'how' (to act in an engaging and supportive way).
- The chair should be mindful of the importance of maintaining high morale among the board members, so as to ensure high levels of constructive engagement and effectiveness of working as a team.
- Research indicates that boards that have a good gender balance are, generally, more effective.
- Boards should be representative of the communities they serve; attempts should be made to increase the proportion of under-represented groups.

Other on-going activities

- Research emphasises the value of boards reflecting on what actually happened during their meetings. The following questions may help in this process.
  - How have we contributed to quality and innovation in the organisation?
  - Have we focused on strategic issues for the trust?
  - Have we been sufficiently challenging? Has this improved our discussions, decisions, and actions? Is there a reluctance to challenge? Why?

- What have we learned? What has surprised us, and why?
- What have we learned about patients' experiences of care in our trust?
- What have we learned about how staff in the trust are coping with the pressures of everyday life?
- How have we supported them, and tried to ensure their wellbeing?
- How can we increase our visibility and promote staff engagement in the trust, so as to strengthen a culture of quality, engagement, and high confidence and morale?
- Should we consult and engage with staff in our work as a board?
- What could we do to increase staff morale?
- Do we celebrate achievement of staff in improving quality and safety of care and experience, and in being innovative?
- How effectively have we worked as a board? What has been done well and what not so well?
- Have all board members contributed to our discussions? Do some board members regularly dominate discussions, and are there some board members who appear reluctant to engage in discussion? What impact is this having on our effectiveness?

Board development

Strategic activity

- Research shows that the most effective boards regard board development as an important activity.

Other on-going activities

- Consider seeking 360 degree-feedback in relation to how effective the board is perceived to be in its leadership and governance role, and how it operates and impacts on members of the board, senior managers, and the wider organisation (eg, as rated anonymously by groups within the organisation, and external stakeholders such as patients, partners, etc). This activity must subsequently be supported by appropriate development activities, such as, workshops for board members, to explore the reasons underlying the ratings, and to support the board's effectiveness as a team, and in their role of being the most senior leaders within the trust.
- Related to the above, consider how the board can engage with those who took the time to provide ratings, including, importantly, staff within the trust. Also, consider how to maximise what can be learnt from the feedback, and commit to leadership development, and to role-modelling an engaging style of leadership.
- Occasionally invite an observer to attend meetings and provide feedback on how the board functions as a board, and how it might work more effectively.
- Spend time together, away from board meetings, for example, on board development days, which might involve some input on a

specialist subject of relevance to the NHS, eg, specific clinical topics, examples of innovation, effective leadership, dealing with change.

- Research indicates that meeting occasionally in a social context, outside board meetings, can improve the cohesiveness of a board.

Shaping a positive culture for the board and the trust

…through a focused process of dialogue and engagement with staff and service users

(National Leadership Council 2010)

Strategic activities

- Address the board's responsibility to adopt an approach to engaging leadership that will embed a culture of high quality and innovation; this should be role-modelled in the way the board works as a team, and in the way board members interact with each other, with individuals and groups within the trust, with patients, and those external to the organisation.
- Board members should seek opportunities to 'get a feel for the culture', and also to increase their visibility in the trust; this could involve engaging with patients and their families, and with staff, in order to create opportunities to listen to, and to learn about, their experiences and concerns; to express interest and appreciation for what is achieved, and to answer questions or explain issues that might be raised.
- Devote sufficient time to discussing the results from staff surveys, and particularly scrutinise them for 'hot spots' in relation to important indicators such as levels of staff satisfaction, motivation, employee engagement, and wellbeing at work, as well as staff confidence in being able to perform their job effectively, and feeling supported; keep a watch for any signs of disengagement among staff, and/or the sense of a 'shame and blame' culture.
- Learn, first-hand, from staff and patients and their families, about their experiences of the culture within the trust; encourage staff to offer input into board discussions.
- Consider undertaking an analysis of the culture of the trust, bi-annually, to provide more structured information about the culture of the trust in perceived; this should include an understanding of the trust's vision, and its impact of its implementation on staff morale and wellbeing.

Other on-going activities

- If the trust has several locations, consider having board meetings in different locations, and use the opportunity to spend some time with local staff to hear about their experiences.
- Consider having a regular opportunity at board meetings for staff to present suggestions for innovation, improvements (in care, and in

relation to organisational culture), successes, achievements, research findings, etc; ensure those most involved in the project are invited to present personally.

- Find ways of celebrating staff's successes, and of sharing their achievements across the organisation, and more widely.
- Consider spending a few days a year shadowing individuals in the trust, so as to be able to see the organisation though others' eyes, and to understand better the challenges they face.
- Conduct staff focus groups, learning walks, and other ways of learning from staff.
- Consider forming a 'buddy' relationship between board members and staff in the trust, including clinicians.
- Discuss, how, collectively as a board, and as individual members, you can create opportunities to 'lift the spirit' of staff, and signal positive expectations; build staff self-confidence and resilience through the support you provide; listen to their concerns, and their ideas, and express your appreciation.
- Exploit the benefits of 'Core conversations', 'Yammer groups', and other social media across the trust, so as to enable staff to connect with each other, and to raise questions, make suggestions, and share experiences.

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