



Effective boards in the NHS?

A study of their behaviour and culture



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NHS Confederation
29 Bressenden Place
London SW1E 5DD
Tel 020 7074 3200 Fax 020 7074 3201
E-mail enquiries@nhsconfed.org
www.nhsconfed.org

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Introduction

Effective boards in the NHS?

This report is based on research into the characteristics of effective boards in the NHS. Our aim is to highlight key issues and prompt debate into how NHS boards perform and what makes them effective.

The research, carried out by the NHS Confederation and the NHS Clinical Governance Support Team, looks at what board members believe are the characteristics of effective boards and how the actual practice of their boards compares with these views.

Based on extensive interviews with board members and observations of board meetings from a cross-section of NHS organisations, the research provides a snapshot of board behaviour and board members' views. It is not intended to be an academic study but is designed to promote debate and provide pointers to areas where more detailed and academic research could be focused.

The research was funded by the NHS Leadership Centre. Interviews and observations were carried out in the summer of 2004.

Executive summary

NHS boards have all the audit and remuneration committees and assurance controls required of any organisation responsible for spending public money. Clinical and, more recently, integrated governance models are increasingly being developed and implemented by boards.

Yet the research found many board members believe there is a need to improve the way their boards work. The board members interviewed identified the behaviour and culture of a board as key determinants of the board's performance. From the interviews, the research identified four characteristics of effective boards:

- a focus on strategic decision-making
- board members who trust each other and act cohesively/ behave corporately
- constructive challenge by board members of each other
- effective chairs who ensure meetings have clear and effective processes.

Our observations of board meetings revealed that boards often fall short of members' expectations and ideals.

A focus on strategic decision-making

Many board members we interviewed saw strategic decision-making as a key aspect of effective boards, yet many of the boards we observed did not spend significant time on strategic issues. The daily grind of operational matters and nationally-set targets often dominated proceedings. Some board members felt disempowered, even overwhelmed, by the need to deliver a centrally-driven agenda.

Board members who trust each other and act cohesively/ behave corporately

There appeared to be a good level of trust within many of the boards observed, although in some boards arguably too high a level of trust.

Constructive challenge by board members of each other

In our observations, executives rarely challenged each other in public board meetings and often kept their contribution to their functional responsibility. Some boards felt obliged to put on a united public face and members were concerned that challenge in a public meeting would reflect badly on the organisation. Challenge, when observed, came from the non-executives who would challenge and scrutinise the executive team and provide a wider perspective to the debate. However, this challenge from non-executives was sometimes poor or overlooked and dismissed in subtle ways – often by simply moving the agenda on without fully responding to the points raised.

Effective chairs who ensure meetings have clear and effective processes

The actual process of the board meetings we observed was not always as sharp and focused as the individual members said they would have liked. At some board meetings little explicit decision-making was observed and agenda items appeared for information without a clear indication of why the board needed the information. Important strategic issues did appear on agendas but without clarity as to why and whether the board was required to take a view. Agenda papers were often long, detailed, difficult to understand and unclear as to what action was required of the board.

While acknowledging the climate of centrally-driven targets and difficult short-term operational problems facing trusts, this paper concludes that board members want their boards to be more focused on strategic issues.

Some boards appear to have become too trusting, with little constructive challenge or debate about strategic issues. Reasons for this lack of challenge include the desire to present a united public face in public meetings. It is clear that the perceived differences between non-executive and executive roles needs to be addressed. Challenge should not

be seen as the preserve of non-executives scrutinising the executive team.

Finally, a culture that enables board business to be conducted in a sharper and more focused manner is required at board level, making clear what decisions are required of the board and what action will follow as a result of the decisions.

This research suggests there is some way to go and more detailed work is required to unpack the complex issues surrounding the culture and characteristics of NHS boards.

Context

Interest in the concept of governance has grown in recent years in both the private and public sectors. Organisations in both sectors now operate in a climate of acute awareness of the need for good governance structures. In particular, the Enron and Transworld corporate scandals in the US put the spotlight on the structures and role of boards. In the UK, the Higgs Report¹ looked at the governance responsibilities of private sector boards and the role of the chair and non-executives in governing organisations.

In light of these developments in the private sector, the Department of Health and the NHS Appointments Commission brought together guidance and good practice on the role of NHS boards and published *Governing the NHS: a guide for boards*.² This guide, which seeks to reinforce the importance of good governance and strategic leadership, was well received by members of the NHS Confederation.

Since the publication of *Governing the NHS*, health policy makers have built on its principles and identified a need for what is now known as integrated governance.

There are two key influences to our research: this concept of integrated governance and the work of Professor Sonnenfeld.

The key components of integrated governance are:

- boards' decision-making is underpinned by intelligent information and public/patient engagement
- governance is moved out of individual silos into a coherent and complementary set of challenges
- boards focus on strategic objectives but know when to focus on more detail
- boards receive clear reports and robust assurance on delegated clinical and operational decision-making
- a well-developed system of assurance controls.

Integrated governance can be defined as:

"Systems and processes by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety, quality and value for money of services, and in which they relate to patients and carers, the wider community and partner organisations."

This paper is also influenced by the theory that board culture and individual board members' behaviour are fundamental to the delivery of high-performing organisations. Professor Sonnenfeld argued in the *Harvard Business Review*³ that in order to identify key determinants of organisational performance, we need to look at the behaviour of individual board members rather than at the structures of the board. Sonnenfeld's article struck a chord among some NHS chairs.

Sonnenfeld argued that good board governance cannot be legislated but can be built over time. The 'best bets' for success are:

- a climate of trust and candour in which important information is shared with all board members and provided early enough for them to digest and understand it
- a climate in which dissent is not seen as disloyalty and in which mavericks and dissenters are not punished
- a fluid portfolio of roles for directors so individuals are not typecast into rigid positions on the board
- individual accountability with directors given tasks that require them to inform the rest of the board about issues facing the organisation
- regular evaluation of board performance.

This research is based on the premise that to deliver integrated governance we need to look not only at the structures of the board but at the behaviour of the individual board members too.

The research

Our research is based on observation of 12 NHS boards during the summer of 2004. The boards were selected randomly to represent a cross-section of organisations in the NHS in England, taking into account type (whether PCT, acute, ambulance, mental health or foundation), geographical location and performance rating according to the Healthcare Commission's star ratings.

Each board was observed at a full board meeting and a number of board members – both executive and non-executive – were interviewed. These semi-structured interviews were designed to explore what board members believed were the characteristics of an effective board and how, in practice, boards lived up to their expectations.

The research identified four main characteristics that interviewees believed made a board effective:

- strategic decision-making
- trust and cohesion
- constructive challenge
- effective board processes.

Strategic decision-making

The board members we interviewed stressed that the core business of an effective board was governance and strategic leadership. Interviewees often identified effective boards as those which rise above operational issues and concentrate on strategic issues. In the words of one PCT chair, "Effective boards look beyond what is happening today and set the direction of travel in a trust."

Board members were also conscious of the need to deliver governance and strategic leadership within a statutory framework as laid out in the Health and Social Care Act 2003. This legally requires board members to discharge eight primary duties:

- to involve patients and public in the planning, delivery and monitoring of services
- to achieve financial balance
- of efficiency and economy, effectiveness and efficacy
- of compliance with authorisations
- of compliance with healthcare standards and national targets
- of quality (as reflected in clinical governance)
- to develop the board
- to work in partnership.

What we observed in board meetings

Despite board members' belief that boards should exist to make strategic decisions and formulate strategy, in some of the boards observed we found little evidence of this work. Important strategic issues did appear on agendas implicitly, but board members often felt it was not made explicit why the issue was on the agenda or what was supposed to happen as a result of highlighting the issue. Moreover, some board discussions tended to be dominated by operational matters – ranging from car park charges to overarching financial pressures. The result was issues of strategy, quality and the patient experience tended to be crowded out.

It was not always apparent in some of the board meetings observed exactly what, how or even if a decision had been taken. One respondent said their board had not made any real decisions in six months.

In four of the trusts observed, conclusions and recommendations appeared at the top of each board paper, ultimately stifling debate and discouraging alternative viewpoints. Even following a good board debate in one trust, the issues raised were simply noted. In extreme cases, silence after a presentation was taken by the chair to mean that board members agreed with what had been

discussed. These are worrying findings given the need for all board members to assure themselves the decisions they make as boards are robust and reasonable, and so legally defensible.

Even where decisions had clearly been taken, some interviewees felt that these decisions, including the reasons they were made and who was responsible for making them happen, were not explicitly recorded. As a result there was no systematic monitoring of how board decisions were acted upon. This lack of monitoring could create ambiguity over who does what and why. Moreover, the lack of clarity around corporate responsibilities with everyone assuming someone else is responsible means key tasks not being addressed.

Improving strategic decision-making

According to many of the board members interviewed, a major reason for the scarcity of strategy and decision-making in the boardroom was that, despite board members' desire to be more strategic, the pursuit of short-term and operationally-focused targets allowed little time. This centrally-imposed agenda contributed towards a sense of disempowerment among some interviewees.

Other interviewees appeared less concerned about the apparent lack of debate at formal board meetings. A number of interviewees simply regarded board meetings as the tip of a decision-making iceberg and that decision-making was an incremental process involving discussion and debate in various places. As the ultimate end point in this process, they regarded one of the purposes of board meetings was to formalise decisions and to get decisions put on record to achieve accountability. However, such an approach may not make use of the wealth of expertise and experience of all the board members. Moreover, it assumes that a more sophisticated process of decision-making has happened elsewhere – which may not necessarily be so.

Trust and cohesion

The majority of board members interviewed believed positive and trusting relationships among

directors were critical to delivering high performance at board level. In particular, a trusting board was a place where people felt safe to challenge. One interviewee commented: "Trust creates a climate where foolish questions can be asked and people feel able to say what they think."

It was clear from our interviews that for trust to exist board members needed to believe their colleagues' contributions were made in the best interests of the organisation and were not motivated by private agendas or ulterior motives. Board members needed to feel their inputs were valued and would not be dismissed or used against them at a later date. Consistency, or doing what you say you will do, was also critical. Finally, board members said they needed to have faith in and respect for each others' abilities – people needed to be good at what they did.

The board members interviewed felt that building trust requires time and that the introduction of periodic away-days (ranging from two away-days per annum to one every other month) was beneficial. Away-days created a greater opportunity for dialogue and facilitated a better understanding of other board members and issues.

The dangers of too much trust

In the interviews, board members also argued that inappropriately high trust could discourage members from actively questioning issues or seeking further information. One PCT chair said: "There is a sense of comfort in the executive directors by the non-executives, developed through confidence that has built up over the past few years. However, this can sometimes lead to insufficient scrutiny which needs to be managed."

In some boards observed, issues were often not pursued and bland reassurances were accepted. This lack of questioning could be the result of too high levels of trust. According to some interviewees, too much trust meant some board members no longer felt the need to prepare for board meetings or to be 'on the ball'. Other interviewees suggested too much trust could create a situation in which executives were allowed to 'do their own thing', setting and pursuing their

own agenda. There was a danger of creating a culture of complacency and an absence of individual accountability.

Some board members interviewed also highlighted the importance of building robust, trusting relationships with staff, patients and other external stakeholders. Transparency was regarded as key. One chair said: "The board needs to promote and protect a culture of openness. This means making information, particularly performance data, readily available and ensuring that staff are aware of how things are handled and how the board has come to make the decisions it has." Involving staff in the decision-making process and encouraging them to challenge the board were seen as important ways of developing trust.

Building trust

Board members identified a range of barriers to creating appropriate levels of trust. Barriers identified included: incompetence of individual board members; failure of board members to acknowledge and act on a problem or to provide information to the board during a time of crisis or significant change; and the failure of individual board members to act in the best interests of the organisation.

Interviewees also argued that unconstructive challenge or tensions created by non-executive directors holding executive directors inappropriately to account for the detailed delivery of the day-to-day operational agenda could reduce trust within organisations.

A high turnover of board members was clearly destabilising in terms of developing appropriate levels of trust, although interviewees commented that some turnover in membership was valuable in preventing boards from becoming stale.

Interviewees said trust was built when board members understood one another – their likes, dislikes and background. It was also helpful for board members to have a clear understanding of each other's individual role, including not only executive or non-executive director roles, but also the roles people prefer to take when contributing in a group situation.

Constructive challenge

All of the board members interviewed believed constructive challenge was critical to board effectiveness. Boards should use challenge to assure themselves their decisions are robust, reasonable and thus legally defensible. "The ability to scrutinise and challenge is fundamental to understanding what the real issues are, and to ensuring effective and informed decision-making," said one executive director.

Previous research has suggested constructive challenge in the boardroom describes a particular kind of conversation and interaction between board members that requires the interplay of three types of behaviours. Work by the NHS Clinical Governance Support Team has described these verbal and non-verbal behaviours as:

- asking penetrating questions that either clarify or expose gaps in the board's understanding of an issue
- actively listening to what is being said
- where necessary, asserting a position until it has been satisfactorily answered or integrated into the discussion.

Legally, there is no distinction between the board duties of executive and non-executive directors since both share responsibility for the direction and control of the organisation. A director of finance, for example, in their capacity as a board member, shares responsibility for the discharge of all of the board's statutory duties, not just those relating to financial issues. Given this overarching corporate responsibility extending well beyond the individual's functional remit, challenge should come from all members of the board, irrespective of their role.

Our study found the frequency and nature of challenge and debate varied significantly from board to board. A number of interviewees reported a total lack of challenge in their board meetings, and this was observed in the board meetings. In other boards where challenge did occur, it was often seen as the job of the non-executive to

scrutinise the work of the executives. Executives very rarely challenged each other or the non-executives. One non-executive director said: “Executives don’t change hats. They are less vocal other than responding to questioning.”

When challenge was observed it came from the non-executives. However, at times non-executives appeared to lack the confidence to challenge any member who was considered an expert in the particular field under discussion. This was especially so when discussing clinical issues.

Furthermore, while apparently the main source of scrutiny, non-executives’ contributions were sometimes either ignored or marginalised by other members of the board. During one discussion we observed on a proposed organisation development strategy, a non-executive asked how to judge whether the activity and effort required by the strategy resulted in a better service for patients. Despite highlighting an important issue, his question was largely ignored.

Where there was lack of challenge, we found that board members often assumed appropriate challenge had taken place outside (often before) the formal board meeting, such as in sub-committees or in the management executive. Non-executives, however, said they were not always confident that an issue had been thoroughly scrutinised elsewhere, with some expressing a sense of a hidden agenda being dealt with separately by the executive team.

Encouraging constructive challenge

There were several important explanations given by those interviewed for the stifling of challenge in NHS boardrooms. Lack of appropriate levels of trust, poor information, incomprehensible agendas and meetings that went on too long were all mentioned.

In particular, many of the board members interviewed believed holding board meetings in public, especially with the media present, stifled debate. Many pointed out the need to present a reasonably collective face to the outside world – challenge would look like disagreement to the

public and would reflect badly on the trust. One board member commented: “The public nature of meetings changes the nature of the board meeting from debating business to mediation with the public.” However, it is interesting to note that, with the exception of mental health trusts where there were often service users present, public attendance was minimal in most of the board meetings observed.

As well as improving trust and quality of information, interviewees suggested a number of strategies that could be effective in increasing the quality and frequency of challenge in the boardroom. Some board members found debates and discussions in forums other than the formal board meeting helpful. Forums outside the formal board meeting, they argued, allowed board members who did not contribute much in formal meetings to contribute more fully to board proceedings. Encouraging contributions might be achieved by promoting challenge in small groups, one-to-one, over the phone or via e-mail, and by giving people time to reflect on any significant issues that have been raised.

Increasing the opportunities for challenge would allow potential contributions to be heard and mean that discussions and debates are not dominated by those who talk the most. One PCT director said: “The introduction of four ‘time-outs’ per annum has been a key achievement for the board. We use them to explore roles as board members, reflect on how well we are doing, debate strategic issues, build relationships among the board and for training purposes.”

Effective board processes and the role of the chair

Many board members interviewed believed that to be effective the board needed effective board processes and that the chair had a fundamental role in ensuring these were effective. One acute trust chief executive said: “An excellent chair is like an orchestral conductor – contextualising things, controlling the agenda and bringing in the non-executives.” Many interviewees stressed how important the chair was in ensuring meetings

allowed appropriate levels of trust, challenge and strategic decision-making to take place.

Board members' views of the role of the chair are confirmed by other research. Earlier studies by the NHS Clinical Governance Support Team^{4,5}, for instance, have stressed chairs' responsibility for creating the right climate to maximise the contribution of each individual board member. Chairs need to ensure a relentless focus on core business and the right balance between trust and challenge. To achieve this balance the chair must be sensitive to team dynamics, recognise each member of the board as an individual and understand the role they prefer to take in a group. For instance, when they are with their board colleagues some people have a tendency to lead, some prefer to innovate and some like to analyse.

According to *Governing the NHS*, for a chair to be capable as the leader of the board, they must excel at:

- setting the board agenda and running productive meetings
- ensuring the provision of accurate, timely and clear information to directors
- facilitating the effective contribution of non-executives and ensuring constructive relations between executive and non-executive directors
- arranging regular evaluation of the board's performance, committees and individual directors
- ensuring effective communication with staff, patients and the public.

What happens in reality

When we observed meetings it was not always clear who the leader of the board was. For example, in one meeting the chair looked constantly to the chief executive to speak or give a lead on issues. In another meeting, the chief executive officer summed up each agenda item once it had been covered. Finally, in one of the PCT board meetings it was observed that the chief executive, deputy chief executive and the PEC chair led most discussions, leaving little room for the chair.

The structure of the agendas for the meetings we observed varied significantly. Some agendas were structured around the functions of the departments while others were structured around policy, performance management, governance, IT and finance. In some meetings, it was made clear in the agenda which items were for noting, information or decision while in other meetings the agendas were confusing. In some boards, observed agendas contained mostly items for noting or information, with little focus on decision-making.

The study found the most common method for presenting information to the board was through papers. The length, structure and complexity of these board papers were major issues. Papers often appeared excessively long, with one set running to 193 pages (some double-sided) and in another board meeting a paper on trust performance alone ran to 66 pages. In a number of instances, internal management papers were simply re-used.

In many of the board meetings we observed, papers were presented by the relevant executive director and this was followed by a discussion or question-and-answer session with the functional specialist responding on behalf of the executive team. However, complex papers were not always well presented which meant the ensuing discussion tended to wander from the salient points.

Finally, we found performance evaluations by boards were patchy. Performance of the board was seen by some as being measured by the performance of the organisation against nationally-set targets (predominantly star ratings). Few evaluations appeared to separate the performance of the board from the performance of their organisation and draw links between the two.

Board members we interviewed were not clear on what information would be helpful to make meaningful and accurate judgements about the performance of the board and/or the organisation. However, a number of people mentioned the importance of 'soft information'. "Soft intelligence often highlights creeping concerns and enables the board to take the

temperature of the organisation which we then use to input into our decision-making," said one non-executive director.

How board processes could be made more effective

Many interviewees stressed the importance of the chair in ensuring meetings were conducted in a style that allowed for appropriate levels of trust, challenge and strategic decision-making to take place – an open style that allows others room to come in.

The style of the chairs varied considerably and the

dynamic between the chair and the chief executive appeared crucial in setting the culture and style of the meetings. The dominance of the chief executive in the meetings and the degree to which the chair tolerated this dominance appeared a major determinant of the effectiveness of the board processes. However, board members also believed that chairs should not become overly dominant themselves.

Many interviewees said agendas tended to be too long and complex, thus stifling discussion and debate. These papers were not always appropriate and some appeared difficult to understand, creating a sense of confusion and, again, stifling debate.

Conclusions

Our research found boards in the NHS could be more focused on strategic issues. The centrally-driven short-term agenda, focusing on targets and the grind of delivering day-to-day operational challenges, is clearly crowding out strategic thinking at board level.

Some boards appear to have inappropriate levels of trust with little constructive challenge. Trust is crucial to developing a high-performing board but misplaced trust can be destructive.

Even within a trusting culture, board members must make constructive challenges. Yet we did not always find this constructive challenge – perhaps partly because the boards wanted to present a united face at public meetings. Boards need to address the perceived differences between non-executive and executive members in order to ensure challenge is not simply seen as the preserve of the non-executives scrutinising the executive team.

Our research suggests NHS boards need to work towards creating a culture that enables business to be conducted in a sharper and more focused manner. It needs to be made clear what decisions are required of the board and what action will follow as a result of the decision. The role of the chair is crucial in sharpening the board's procedures and creating the right culture.

The development of concepts such as integrated governance will hopefully drive this agenda forward. But this research suggests there is some way to go and more detailed work is required to analyse these complex issues around the culture and characteristics of boards in the NHS. It must also be remembered that NHS boards have additional pressures such as the requirement to hold meetings in public and complexities such as meeting externally imposed targets.

It was clear during the research that NHS boards are not the only sector trying to get to grips with these issues. Many other sectors, including the commercial sector, are trying to create the right culture and behaviour of boards to ensure they add maximum value to their organisation.

It was encouraging that many members of the boards recognised the shortcomings of their board meetings and are looking to improve the way they work. Some boards were already exploring ways of improving their processes and culture. Others were undertaking training and using some of the board development tools provided by the NHS Clinical Governance Support Team. The current debate around integrated governance and the new governance structures of foundation trusts are generating new ideas too. This report aims to help this debate by publicly articulating the views that many board members are articulating amongst themselves.

The NHS Leadership Centre, the NHS Clinical Governance Support Team and the NHS Confederation will be reviewing their activities around supporting boards. There appears to be unmet need for board training and development. The NHS Confederation will:

- test the findings of this report with its wider membership
- explore further with its membership the role that it could play in acting as a catalyst for change in this area
- identify areas where it could provide additional support to chairs, executive and non-executive board members
- continue its work with the Healthcare Commission and Monitor in their work around assessing and regulating NHS organisations, to see how the performance of the board can be properly assessed.

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NHS boards have all the audit and remuneration committees and assurance controls required of any organisation responsible for spending public money. Clinical and, more recently, integrated governance models are increasingly being developed and implemented by boards.

However, research indicates that boards often fall short of members' expectations and ideals and many board members believe there is a need to improve the way their boards work.

Based on extensive interviews with board members and observations of board meetings from a cross-section of NHS organisations, *Effective boards in the NHS?* provides a snapshot of board behaviour and board members' views. It is not intended to be an academic study but is designed to promote debate and provide pointers to areas where more detailed and academic research could be focused.

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