



Factors associated with clinical focus in NHS Trust Boards

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EXECUTIVE SUMMARY

Previous studies have implied that greater clinical focus at Health Service Board level will improve the range, quality or cost of clinical care; in this study we sought to identify the factors that influence clinical focus at NHS Trust Board Meetings and to examine any relationships between these factors. The research was conducted in three phases: Phase 1: review of Board meeting minutes (n=105 Trust Boards); phase 2: observation of Board meetings (n= 8 Trust Boards; 3 meetings per Trust) and phase 3: survey of Board members across NHS Trusts in England (n=294) to examine areas of interest, relationships between Executive and Non Executive Board members and self-rated contribution to meetings.

For Phase 1, there were a total of 298 trusts listed on the DH and Monitor websites in February 2008: 150 PCTs, 92 acute non-FTs and 56 FTs. Minutes from 35 randomly selected Trusts for each of the three types of Trust were downloaded from trust websites (total 105 sets of minutes). Two issues arose during this process: availability and accessibility of minutes. For Foundation Trusts, 38% of sets of recent minutes were not available, whereas for both acute and PCTs only 8% of sets of recent minutes were not available. This difference was statistically significant ($\chi^2 = 17.4$, $df=1$, $P < 0.001$). Where Foundation Trusts' minutes were present, many were not easy to find; many required the website 'search' facility to locate them.

A coding frame was developed, extensively pilot tested and used to code the 105 sets of minutes. The total number of items (both clinical and non-clinical) in the minutes of the 105 Trusts ranged from 17-114. One-way analysis of variance (ANOVA) revealed that PCTs recorded more items (mean 61) than Acute Trusts (mean 50) who recorded more items than Foundation Trusts (mean 38), ($F=11.7$, $p < 0.001$). The percentage of these that were clinical ranged from 0-51%. There was no difference in the percentage of clinical items by Trust type. There were significant differences between Trusts for three of the six types of clinical item. A bigger proportion of all items for PCTs were classified as 'Service Design' compared to Acute Trusts and Foundation Trusts ($p=0.028$) and fewer were classified as 'Clinical Outcomes' ($p=0.035$). Foundation Trusts had more items classified as 'Activity Levels' than Acute or PCT ($p=0.027$). In order to construct a sample matrix for Phase 2 (observation of Board Meetings), all Trusts used in Phase 1 were classified as having high or low clinical content in Board meeting minutes.

All Trusts were in a period of transition at the time of Phase 2 data collection: a) Foundation Trusts were embedding in their new roles and managing the process of having two Boards (Directors and Governors); b) Primary Care Trusts had recently undergone mergers and were grappling with provider and commissioner roles, whilst also needing to embed the requirements of *World Class Commissioning* processes; and c) the Acute Trusts used in the study were both in the lengthy process of applying for Foundation Trust status. Whilst this clearly had an impact on the interaction between the Executive and Non Executive members of the board, each Trusts was in a similarly 'dynamic' state, albeit for different reasons.

The eight sites used for Phase 2 were a purposive convenience sample based on three binary variables (2X2X2): Foundation versus non-Foundation Trust; Primary Care versus Acute

Trust; high versus low clinical content. The sites were from a wide geographical area and linked to five different Strategic Health Authorities. Observation of Board meetings revealed a number of dynamics not evident in the (publicly available) meeting minutes; these are summarised under four themes: similarities and differences between Boards; interaction between Executive and Non-Executive Directors; comparison between observation and meeting minutes and function of Part 2 (private) Board Meetings.

All Board meetings observed were similar in the following four respects: **chair-led**: the conduct of the meetings was determined by the direction provided by the chair; **collegial in nature**: there was no obvious conflict in any of the Board meetings observed; **the level and extent of discussion came from the Non-Executive Directors**: and **discussion was driven heavily by current government policy initiatives** (for example, waiting times/rates of MRSA and *C.Diff* infection). The two areas of marked difference between Boards were: the extent of public questioning and the extent of pre-planning taking place before the Board meeting.

Interaction between Board members was not evident in meeting minutes. Central to discussion of clinical issues was the role of Non Executive Directors, for example their embeddedness in formal governance structures, and their freedom/willingness to question the Executive Directors. Analysis of observation data revealed **six types of questioning tactic** used by Non-Executive Directors: supportive questioning; what lessons had been learnt; seeking contextual explanation; seeking information; seeking strategy and requesting further work. For the most part the questions raised by Non-Executive Directors were not reported in the meeting minutes. On the whole a greater proportion of the questioning from Non-Executive Directors in the PCTs related to strategy. This may reflect the state of play at the time of data collection; much of the discussion in the private part of PCT Board Meetings related to the dual role of commissioner and provider and, in particular, to the strategic intent of the Non-Executive Director role in sub-committee structures. In the Acute Trusts, both of which were preparing applications for Foundation Trust, the Non-Executive Directors were more likely to request further work in the Part 1 meetings.

Minutes were not a reliable indicator of board meeting activity in the public part of Board meetings observed; some items discussed at the meeting did not appear in the minutes and, with one Board in particular, items appeared in the minutes that had not been discussed. Where this happened the inclusion was not queried when minutes were ratified at the next Board meeting. However, whilst the level of detail contained in minutes was variable, the ratio of clinical to non-clinical discussion that was observed was also reflected in the minutes, suggesting that the Phase 1 data do have some validity. This held true across the two phases of data collection: Trusts sampled because of high [low] clinical content in Phase 1 also demonstrated high [low] clinical content in Phase 2.

The sample size for the survey (Phase 3) was fairly large (n=294) but the response rate was relatively low (21%). The response rate between Executive Director and Non-Executive Director was similar and we have no reason to believe that non-responders would have answered differently. We found statistically significant differences for some items between Board members by type of Trust (Acute, Foundation or Primary Care) and by type of Board member (Executive or Non-Executive). Board members at Acute Trusts were significantly

more interested in 'clinical outcomes', 'activity levels' and 'finance' and Primary Care Trust Board members were significantly less interested in human resource issues. In terms of self-rated contribution to the last Board meeting, Primary Care Trust Board members were less likely to have contributed to discussion regarding 'clinical outcomes', 'activity levels', 'finance' and 'human resources'. These findings are not surprising given the roles of different types of Trust and the likelihood that Acute Trusts are aspiring to become Foundation Trusts. Non-Executive Directors were least interested in 'finance' but more likely to contribute to finance-related discussions; this suggests (perhaps reassuringly) that they see financial challenge as a key component of their role, regardless of their personal interest.

Our data demonstrate that NHS Trust Boards are no different from other Boards; the quality of challenge depends on, firstly, characteristics of the individual members, from Chair to Non-Executive Director, and, secondly, the quality of consumer [patient] representation. In order to fulfil goals of robust stewardship and sound governance, Trusts Chief Executives and Chairs should pay attention to: preparation for role of Non-Executive Director, clarification of governance processes and clear processes for public scrutiny and public involvement. We observed many examples of good practice during the process of undertaking this study, many of which are contained in this report; however, findings reveal that there is still much progress to be made.

STUDY CONTEXT AND DESIGN

1. Introduction

Note: Throughout this report the term 'Acute Trust' is used to refer to an Acute (non-Foundation) NHS Trust. The term 'non-Foundation Trust' is used on occasion to refer to Acute and Primary Care NHS Trusts.

Previous studies have implied that greater clinical focus at Board level will improve the range, quality or cost of clinical care^{1, 2}. In 2006, the Burdett Trust for Nursing supported a pilot study of the degree of 'clinical focus' of decision-making at Board level (*An exploratory study of the clinical content of NHS Trust Board meetings in an attempt to identify good practice* Watkins, Lindsey & Jones 2006). Taking 'clinical focus' to mean 'a relatively high proportion of clinical content', in the sense of attention to the health care processes (including preventive and diagnostic interventions) experienced by the provider's patients, the study findings³ suggested the hypotheses that:

- the degree of public participation ('lay attenders') in Board meetings correlates with degree of clinical focus
- clinical focus is greater where (and because) CEO links non-clinical issues to clinical ones during Board meetings
- the extent of lay attenders' role in Board meetings correlates with the degree of clinical focus

Another report, which the Burdett Trust co-sponsored with the OPM⁴, implied the following additional hypotheses:

- financial constraints (including staff shortages) restrict the influence of clinical executive directors
- clinical focus is greater where clinical executive directors have the skill, confidence and tenacity to consistently bring 'the bedside to the boardroom'
- clinical focus at Board level is greater in Trusts where there are clear structures and processes for clinical accountability.

If verified, these hypotheses would be of considerable practical importance both for NHS management, in particular the role of nurse managers; for the management of clinical quality in NHS services; and for health policy in regard to the accountability of NHS Trusts. The study presented in this report began testing (verifying or refuting) these hypotheses

¹ Davies H, Nutley S & Mannion R (2000) Organisational Culture and Quality of Health Care *Quality in Health Care* 9; 111-19.

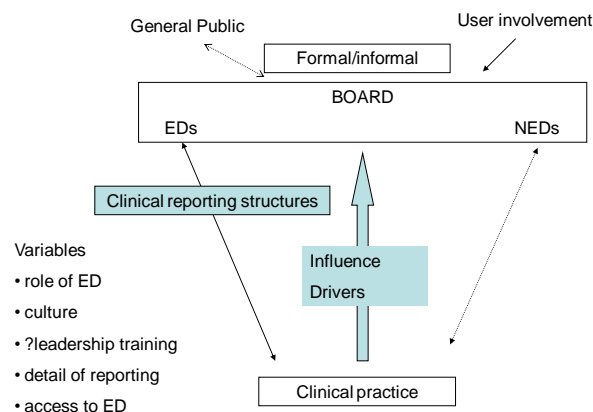
² Marshall MN, Mannion R, Nelson EA and Davis H (2003) Managing change in the culture of general practice: qualitative case studies in primary care trusts' *British Medical Journal* 327: 599-602.

³ Watkins M, Jones R, Lindsey L & Sheaff R (2008) The clinical content of NHS trust board meetings: an initial exploration *Journal of Nursing Management* 16: 707-715

⁴ Burdett Trust (2006) Who cares, wins: leadership and the business of caring. London: Burdett Trust for Nursing & OPM

empirically. Given the role of nurses on NHS Trust Boards, understanding the membership and working processes of these Boards could be expected to make an important contribution to the managerial development of those nurses who already are Board members, and for nurses who hold or aspire to senior managerial roles. The clinical leadership of nurses at Board meetings has been addressed through a programme of work undertaken by the King's Fund with support from the Burdett trust for Nursing⁵. We sought specifically to identify the factors that influence clinical focus at Board Meetings and to examine any relationships between these factors (see Figure 1).

Figure 1 Potential relationships explored through the study



2. Study Aims and Research Questions

Aims

1. To identify factors that influence clinical focus at Board Meetings
2. To examine relationships between these factors

Research Questions

1. How much do Trust Boards memberships vary in terms of:
 - occupational background (lay, clinical, managerial, other)
 - the kinds of decisions and managerial questions that members of different occupational background are most interested in?
2. How much variation is there between boards of directors in different NHS organisations regarding their:
 - proportion of clinical content ('clinical focus') in their meetings

⁵ King's Fund (2009) From Ward to Board: identifying good practice in the business of caring. King's fund, London.

- proportion and clinical focus of lay participation
 - proportion and clinical focus of clinician participation
 - the character of Chief Executives' contributions, in particular any linking of non-clinical with clinical content or issues
3. How do Foundation, Acute and Primary Care Trusts differ in the above respects?
 4. How do mechanisms for clinical accountability, vary across Trusts?
 5. How much do Foundation Trust Boards of Directors and Acute/Primary Care NHS Trust Boards differ in organisational dynamics?

3. Study Design and Methods

The research was conducted in three phases:

Phase 1	Review of Board meeting minutes (n=105 Trust Boards)
Phase 2	Observation of Board meetings (n= 8 Trust Boards; 3 meetings per Trust)
Phase 3	Survey of Board members across 105 NHS Trusts in England (n=1400)

3.1 Phase 1 Methods

In order to analyse NHS Trust Board Meeting minutes, an instrument for categorising the clinical and non-clinical content of discussions and decisions was developed from the following sources:

1. Watkins et al.'s paper⁶, supplemented with a literature search for any similar instruments;
2. Published minutes of meetings from ten NHS Trust Boards (Foundation, Acute and Primary Care);
3. Theoretical accounts (e.g. in Friedson⁷, Foucault⁸, Mannion et al⁹) of the nature of clinical work and how it differs from other kinds of work (e.g. managerial work, financial work) that Boards also undertake.

⁶ Watkins M, Jones R, Lindsey L & Sheaff R (2008) The clinical content of NHS trust board meetings: an initial exploration *Journal of Nursing Management* 16: 707-715

⁷ Freidson, E (1984) The changing nature of professional control *Annual Review of Sociology* 10: 1-20.

⁸ Foucault M (1973) *Birth of the clinic* London: Tavistock

The coding tool examined clinical items and non-clinical items as listed below:

Clinical items	Non-clinical items
<ul style="list-style-type: none"> • Service design and standards • Clinical ethics • Clinical outcomes • Referral routes and volumes • Activity levels • Evidence-based care 	<ul style="list-style-type: none"> • General board processes • NHS national agenda • Finance • Organisational issues • Staffing • Patient feedback

All of these items were further broken down to provide detailed categories to ensure accurate coding (see Appendix 1).

Extensive pilot work was undertaken to establish validity and reliability for the tool. Sets of minutes were rated by all four members of the research team and specific written criteria were agreed for the coding content and process (see Appendix 1). The instrument was then used to analyse publicly-available minutes from 105 NHS trusts (35 each of Foundation, Acute and Primary Care NHS Trusts). A consecutive sub-sample of 25 was coded independently by two researchers to check inter-rater reliability; median agreement across the 25 sets of minutes was 95%.

Content analysis assumes that the published records (Phase 1) are an accurate reflection of the distribution of the content of the meetings. However, the method used in Phase 2 allowed us to check this assumption and identify any gross systematic discrepancies between the observed meeting and that recording in the minutes.

3.2 Phase 2 Methods

Following Phase 1, eight Boards were invited to participate in Phase 2. Maximum variation sampling was used to identify: 1. Trusts with highest and lowest numbers of clinical items reported in Board meeting minutes; 2. a mix of Foundation, Acute and Primary Care Trusts. Three sources of data were used for each meeting: observation field-notes recorded by the researchers; Board papers; and Board Meeting minutes. These data were content analysed using framework analysis¹⁰, a process comprising five stages: familiarisation, defining a thematic framework, indexing, charting and mapping/interpretation. The thematic framework was derived from the codes used in Phase 1 and refined using themes emerging from the data.

⁹ Mannion, R. Small, N. Thompson C. (2005) Alternative futures for health economics: implications for nursing management *Journal of Nursing Management* 13: 377-386

¹⁰ Pope C, Ziebland S, Mays N. Analysing qualitative data. *British Medical Journal* 2000; 320:114-6

To establish reliability for the observation tool, two observers simultaneously coded the contents of Board Members' contributions directly observed at the meetings and published minutes of the same meetings. Pilot work also allowed us to:

- a) remove any ambiguity in the categorisation and coding of meeting contents and
- b) identify any systematic ways in which the content (and therefore coding) of minutes appears to differ from the content (and therefore coding) of directly-observed meetings. This would then provide a method for allowing subsequently for any likely recall bias in Board minutes (or, more accurately, recall bias in Board minute-takers).

3.3 Phase 3 Methods

The aim of Phase 3 was to ascertain:

- areas of most and least interest to Trust Board Directors, both executive and non-executive.
- self-reported relationships and collaboration with other Board members.
- self-reported pattern of participation in Board meetings.

A cross sectional survey was undertaken using a questionnaire, designed using the concepts in the coding instrument that was developed, tested and used in Phases 1 and 2 of the study. In order to establish reliability, the survey instrument was piloted on two occasions with two Trust Boards used for Phase 2. Eight of the eleven survey items reached statistical significance at $p=0.05$ or less for correlation. The three areas that did not reach significance were board members level of interest in the following areas: 'clinical ethics and governance', 'human resources' and 'patient feedback'. These are the areas that generally scored less in Phases 1 and 2; levels of interest in these three areas tended to wax and wane dependent on the context in which they are discussed - for example, a patient complaint could suddenly evoke high levels of interest from members if it reflected poorly on the organisation. Similarly, interest in human resources may be variable - if there were a staffing crisis affecting care-giving or achievement of targets, interest in it may move up the scale. Clinical ethics and governance may attract more interest if there were an ethical dilemma, such as medication costs, or issue with implementation of evidence based practice. As these areas were not routinely discussed in meetings but only when there were issues with any of them, it could be predicted that levels of interest may alter on two separate occasions, hence these questions were not amended as a result of the pilot study. The survey was sent to all Board members in the 105 Trusts used for Phase 1.

Cross-sectional analysis was undertaken, with simple statistical testing (e.g. chi-squared test), of the associations between:

- 1 issues of most / least interest to Board members and clinical focus
- 2 self-reported relationships / collaboration with other Board members, and clinical focus.
- 3 self-reported pattern of participation in Board meetings and clinical focus.

SECTION A PHASE 1 ANALYSIS OF BOARD MEETING MINUTES

Findings from Phase 1 have been presented at the 2008 *European Health Management Association* conference and published in *Nursing Standard* (see full citations and abstracts at Appendix 2).

4. Phase 1 Sample and Recruitment

Minutes from Foundation, Acute and Primary Care Trusts were examined. NHS trusts incorporating social care aspects, such as mental health partnership trusts, were excluded as the social care aspects of meetings may have caused bias in the results.

There were a total of 298 trusts listed on the DH and Monitor websites in February 2008: 150 PCTs, 92 acute non-FTs and 56 FTs. As part of the data collection for Phase 1, it was noted how easy or otherwise minutes were to access; differences that occurred are reported and discussed below. A random sample of 35 from each type of organisation was initially selected using a random number table and attempts made to download the most recent set of minutes from Trust websites at the end of February 2008. Sample size was based on statistical power (80% power to find a difference between two proportions - 90% and 55-60%).

The number of 'mouse clicks' required to retrieve information is an intuitive, simple, and frequently used measure of navigability (<http://www.usability.gov/refine/testplan.html> ; <http://www.links.com.au/usability.php>). We recorded the number of clicks required to retrieve the minutes.

5. Phase 1 Results: availability and accessibility of meeting minutes

Access to minutes from Trust websites revealed a statistically significant difference by type of Trust. In addition it was found that Foundation Trusts were increasingly choosing to hold Board of Directors meetings in private and not posting these minutes on the Internet. These findings formed the basis of a paper (Woodward et al 2009 – see abstract at Appendix 2).

Thirty five sets of minutes from each type of organisation were downloaded from trust websites representing the minutes for a total of 105 NHS trusts. Two issues arose during this process: availability and accessibility of minutes.

Availability of minutes

For PCTs and Acute Trusts the minutes were located for most of the sampled trusts in four clicks of the mouse once the website was entered. Three sets of minutes in each group could not be accessed; therefore a second random sample was selected from the original trusts listed to make the sample numbers up to 35 for these groups. However, for Foundation Trusts it was far more problematic to access minutes and the researchers had to visit the websites of all 56 acute Foundation Trusts to obtain the required sample size of 35. This meant that for Foundation Trusts, 38% of sets of recent minutes were not available, whereas for both acute and PCTs only 8% of sets of recent minutes were not available.

The difference between the availability of board meeting minutes of foundation and non-foundation trusts was found to be statistically significant ($\chi^2 = 17.4$, $df=1$, $P < 0.001$).

Accessibility of minutes:

Where Foundation Trusts' minutes were present, many were not easy to find. Only 18 sets of Foundation Trusts' minutes could be accessed in four mouse clicks and many required the website 'search' facility to locate them. Other problems included the following:

- Although 24 Foundation Trusts posted minutes of meetings held between October and December 2007, another 12 had old minutes posted on their websites (September 2007 or older). This compared with three sets from PCTs and three sets from non-foundation trusts that were older than September 2007.
- Twelve (34%) Foundation Trusts had minutes from their boards of governors on the websites but none from their boards of directors. Most of these provided a summary report from the board of directors' meeting ($n=7$), the remainder had a report from the chief executive as part of their governors' meeting.
- Eight Foundation Trusts (23%) had no minutes on their websites. Some of these stated that information could be obtained by writing to the freedom of information (FOI) officer and charges that might be made.

For the 12 Foundation Trusts with Board of Governors' meeting minutes only, several stated that the Board of Directors' meetings are now held in private. A few Foundation Trusts where minutes were available also stated that the Board of Directors' meetings were going to be held in private from later in the year (2008).

Searching non-foundation trust – acute and PCT – websites yielded different results. Searching was easier, with most minutes located in three or four clicks. The search term 'board meetings' (needed for 31 Foundation Trusts) was only needed for six non-foundation trusts. Most non-foundation trusts kept their board papers in the 'About us' section of the website (30 Acute Trusts and 31 PCTs). A few had direct links from the home page to information about board meetings or minutes, and those minutes could be accessed in one or two clicks after entering the website.

6. Phase 1 Results: clinical content

A one-way analysis of variance (ANOVA) was undertaken of the final sample of 105 sets of minutes following coding, using the Statistical Package for Social Sciences (SPSS), initially comparing clinical and non-clinical items overall by type of organisation, and then a more detailed ANOVA which incorporated all the specific items in each category.

The total number of items (both clinical and non-clinical) in the minutes of the 105 Trusts ranged from 17-114 (Figure 2). PCTs recorded more items (mean 61) than Acute Trusts (mean 50) who recorded more items than Foundation Trusts (mean 38), ($F=11.7$, $p < 0.001$). The percentage of these that were clinical ranged from 0-51%. There was no difference in the percentage of clinical items by Trust type.

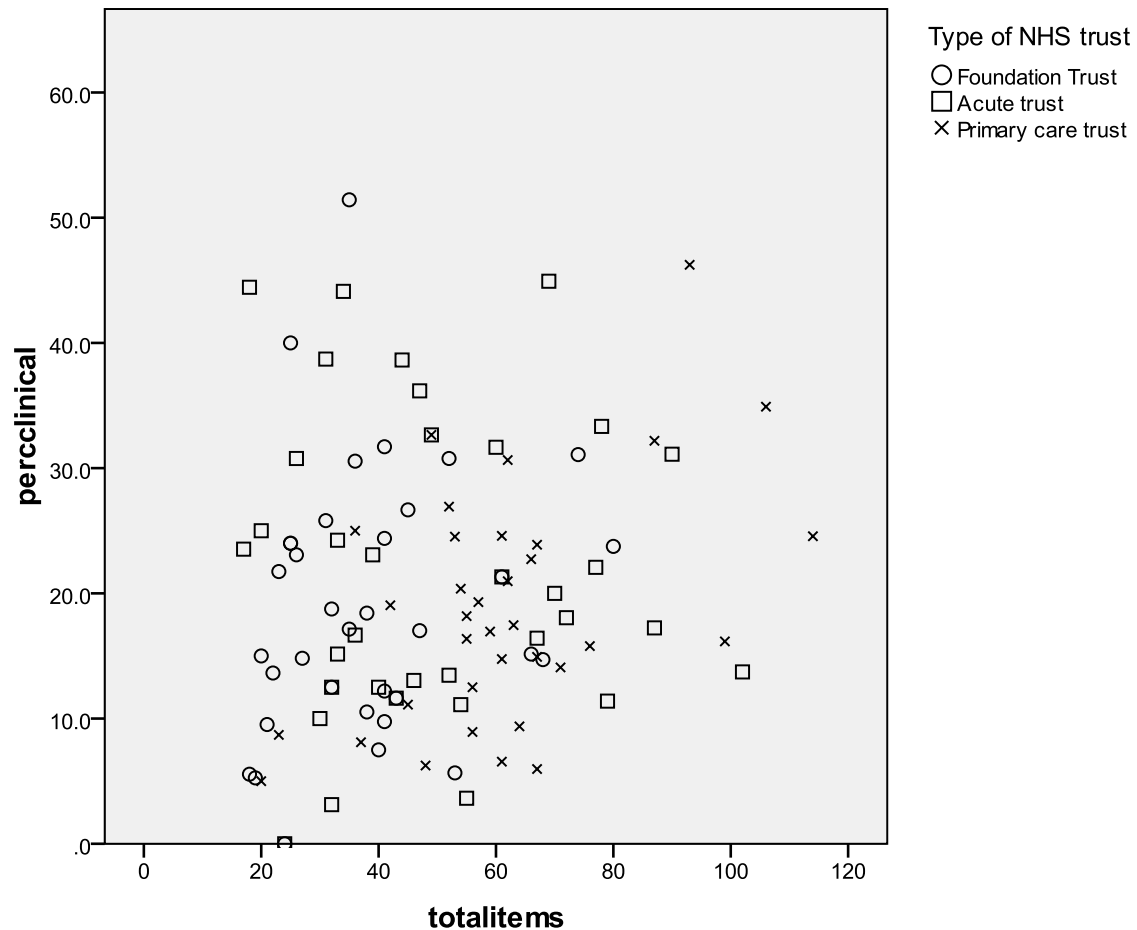


Figure 2. Scattergram of total number of items recorded and percentage of those items which were classified as clinical, showing the Primary Care, Acute, and Foundation Trusts.

6.1 Similarities and differences between types of NHS organisation

There were significant differences between Trusts for three of the six types of clinical item. A bigger proportion of all items for PCTs were classified as ‘Service Design’ compared to Acute Trusts and Foundation Trusts (9% Vs 8% Vs 5%; $F=3.7$, 2df, $p=0.028$) and fewer were classified as ‘Clinical Outcomes’ (6% Vs 10% Vs 8%; $F=3.4$; 2df, $p=0.035$). Foundation Trusts had more items classified as ‘Activity Levels’ than Acute or PCT (4% Vs 3% Vs 2%; $F=3.7$; 2df, $p=0.027$). Examples of categories for these three items are at Table 1. There were no differences between Trust types for ‘Clinical Ethics’ (0.3%), ‘Referral Routes and Volumes’ (1.3%), or ‘General Board Processes’ (0.2%).

Table 1 Examples of categories in ‘service design’, ‘clinical outcomes’ and ‘activity levels’ items

Service Design	Clinical Outcomes	Activity Levels
Range and volume of services	Morbidity	Emergency Dept usage
Risk management	Unplanned readmissions	Average length of stay
Prescribing	Clinical targets	Case mix

6.2 Overall rating of clinical content

Following Phase 1, a more detailed analysis of Board of Directors meetings was then undertaken using direct observation in eight NHS organisations (Phase 2) to examine the content of meetings using different methods. In order to construct a sample matrix for Phase 2, all Trusts used in Phase 1 were classified as having high or low clinical content in Board Meeting minutes.

SECTION B PHASE 2 OBSERVATION OF BOARD MEETINGS

As expected, observation of board meetings revealed a number of dynamics not evident in the (publicly available) meeting minutes; these are presented below under four themes: similarities and differences between Boards; interaction between Executive and Non-Executive Directors; comparison between observation and meeting minutes and function of Part 2 (private) Board Meetings. Anonymised extremes of Board practice and 'typical' practice are included throughout. Where exemplars are given Trusts are noted as trust x, y, z; however, in order to preserve anonymity, Trust x in Box 1 is not necessarily the same Trust as Trust x in Box 2.

Findings are prefaced by an overview of the context at the time of data collection.

7. Context of Phase 2 data collection

All Trusts were in a period of transition at the time of data collection:

- Foundation Trusts were embedding in their new roles and managing the process of having two Boards (Directors and Governors)
- Primary Care Trusts had recently undergone mergers and were grappling with provider and commissioner roles, whilst also needing to embed the requirements of *World Class Commissioning* processes;
- The Acute Trusts used in the study were both in the lengthy process of applying for Foundation Trust status.

Whilst this clearly had an impact on the interaction between the Executive and Non Executive members of the board, each Trusts was in a similarly 'dynamic' state, albeit for different reasons. There were, however, no changes between executive or non-executive board personnel during the data collection period.

At the time of data collection, the role of the Professional Executive Committee (originally intended to introduce primary care clinicians into the formal NHS management structures and to provide a focus for clinical leadership) in Primary Care Trusts was under review (DH/NHS Alliance 2006) with a predicted change in focus from advisory role to participation in decision-making. In the four PCTs observed the role of the PEC Chair appeared to be advisory only.

The Darzi Review¹¹ was in the early stages of discussion during the period off data collection hence none of the Trusts had started the process of preparing 'quality accounts'. Indeed the Darzi 'polyclinic' idea was the subject of greater discussion, both for Executive and Non-Executive Directors.

¹¹ Department of Health (2008) High quality care for all: NHS next stage review final report. Cm 7432 London: Department of Health

8. Phase 2 Sample and participants

The eight sites were a purposive convenience sample based on three binary variables (2X2X2): Foundation versus non-Foundation Trust; Primary Care versus Acute Trust; high versus low clinical content. The sampling strategy was not constrained by Trust Boards' willingness to participate in regard to the availability of publicly-accessible documents and meetings, but was so constrained in regard to access to other data sources. In practice, this applied particularly to the two Acute Trusts where access to the private meetings was denied. One Acute Trust refused outright; the Board Chair gave the request no consideration, stating that the researchers would 'get everything they needed from the public meetings'. The second Acute Trust refused access because they were preparing for Foundation Trust application and had Monitor observers present in Pt 2 meetings. As this was likely to apply to most Acute Trusts the decision was taken to remain with the two Trusts as these were purposively selected according to the sample frame. One Primary Care Trust did not refuse access but was sufficiently disorganised that a decision about access had not been taken by the time data collection ended. The Trust Boards used for Phase 2 were from a wide geographical area and were linked to five different Strategic Health Authorities.

9. Phase 2 Findings: similarities and differences between Boards

All Board meetings observed were similar in key respects:

- **Chair-led:** the conduct of the meetings was determined by the direction provided by the chair. Three examples of this are provided at Box 1.
- **Collegial in nature:** there was no obvious conflict in any of the Board meetings observed
- **Level and extent of discussion comes from the Non-Executive Directors:** some Non-Executive Directors were challenging and questioning whilst others said little during the meetings. The extent of this variation was not related to type of Trust. Some Chairs were notably better at encouraging discussion and debate than others.
- **Discussion driven heavily by current government policy initiatives** (for example, waiting times/rates of MRSA and C.Dif infection)

Box 1 Examples of Chair behaviour

Trust x

The Chair did not invite discussion during Part 1; questioning of Executive Directors only took place if it was initiated by the (Non-Executive) Board members. Of note, at one meeting in this Trust the Chair was absent and the Vice Chair took a different approach; there was much discussion and the meeting was over an hour longer. Non-verbal cues (for example, body posture and eye contact) also implied that the Board Members were more relaxed under the chairmanship of the Vice Chair.

Trust y

The Chair seemed unable to curtail discussion or prompt decision-making. As a result meetings were lengthy with some agenda items seeming to go round in circles without reaching a conclusion.

Trust z

During the private (Part 2) meeting that preceded the Part 1 meeting, the Chair asked the Non Executive Directors to take the lead on questioning for each agenda item. Meetings were inclusive with members of the public, executive and non-executive directors all given 'airtime'.

There were two areas in which there were notable differences between Boards.

- **the extent to which questions were taken from the members of the public**
- the extent of '**pre-planning**' taking place in the **private part** of the Board Meeting.

These are examined in more detail below.

9.1 Public involvement

The extent of public engagement at Board Meetings was variable, as indicated in the exemplars provided at Box 2. Where members of the public provided a formal 'representational' role, most commonly from the Patient Involvement Forum (PIF), the content of questions posed was also variable. In two of the eight Trusts, the questions were extremely well-informed, constructive and generated discussion amongst Board Members, for example:

We have noted some problems with communication between patients and health care professionals of all professions for example[examples provided of poor communication]. However, sometimes the communication is excellent [examples provided of good communication]. How do we ensure that the poor communication doesn't happen? [Obs/Acute Trust]

We need to think about the terminology used when discussing the contracting out of services; can private companies be patient focused?[obs/PCT]

When new equipment is purchased for the wards, do patients ever get the chance to talk to manufacturers/suppliers? Patients may notice things that nurses and doctors don't. [obs/PCT]

By contrast, in another Trust the PIF representative was invited to pose questions at each meeting but generally did not. The only question posed related to the rise in car parking fees for visitors. In all 24 board Meetings observed, questions from the public were taken by the Executive Directors or the CEO. The role of the Chair, where s/he engaged in the discussion, was to ensure that the questioner was satisfied with the response.

The extent of public attendance may well have been triggered by specific events. During the Part 2 meeting at one Trust the Board noted that recent events that had generated media attention might result in additional members of the public attending the meeting. In another Trust, the Board members were advised that a particular agenda item might increase public attendance. In the former the information was provided for information only and was simply noted by Board members. In the latter, this was couched as a warning and generated questions such as 'who will handle questions?' 'how will we respond if they ask about xx?'. In both of these instances there was higher public attendance than usual but no questions were raised, indicating that they were satisfied with the Board's handling of the agenda items in question or did not feel sufficiently comfortable to ask questions.

Box 2 Contrast between extent of public engagement in two Trusts

Trust x

No members of the public attended Part 1 of the three meetings observed; this was not commented on and seemed to be usual practice. Review of minutes from subsequent meetings indicates that this remains the case.

Trust y

There were significant planned opportunities for the public to interact with Executive and Non-Executive Board members, both during the Part 1 meeting, with regular invitations for questions from the public, and during the sandwich lunch provided for Board Members and lay attendees.

9.2 Extent of pre-planning

Some Board Chairs used the private meeting to brief Board members on matters that were confidential and not to be discussed in the public meeting (for example staffing matters, Serious Untoward Incidents, commercial contractual details). Other Boards used this time to agree strategy for the board meeting – which Non-Executive Director would lead the questioning on which agenda item etc. Some Boards held the private part after the main Board meeting; in one Trust the public Board meeting lasted an average of 45 minutes and was followed by a private Board meeting lasting for 5 hours. There was also a degree of 'reputation management' evident in the private part of meetings at some Trusts.

These ‘similarities’ and ‘differences’ findings emphasise the central role of the Chair (rather than the Chief Executive, as suggested by Watkins and colleagues¹²) in setting the ‘tone’ of the Board Meeting. In governance terms, this would seem entirely appropriate.

10. Phase 2 Findings: Interaction between Executive and Non-Executive Directors

In addition to the above similarities and differences, which could not be gleaned from review of minutes undertaken in Phase 1 of the study, interaction between Board Members was also not evident in the minutes. Central to clinical discussions is the role of Non Executive Directors and their ability/freedom to question the Executive Directors. Data analysis suggests there are two dimensions to this dynamic:

1. *How the Non Executive Director role is set up at organisational level (for example, the embeddedness of the Non-Executive Directors in governance structures and roles undertaken by the Non Executive Director)*
2. *Contribution made by the individual Non Executive Director*

These are discussed below.

10.1 Governance

The role of the Non-Executive Directors varied across Trusts; most were chairing committees, for example the clinical governance committee or audit committee, depending on their skills. However, whilst they seemed to be embedded into Trust structures, there was also considerable discussion regarding their role during the Part 2 [private] meetings, as illustrated in the following data excerpts:

“The Non-Executive Directors are being used in too operational a manner; the NED role should be to challenge the Executive Directors”

“We need maximum engagement between the Non-Executive Directors and the Executive Directors”

“We need to ensure that the Non-Executive Directors are kept in the loop [regarding media interest in a particular Serious Untoward Incident]”

“The NED should ensure that appropriate advice has been taken”

There was clearly an awareness of training requirements for the non-executive directors across all the Trusts for which Part 2 meetings were observed.

At one Trust the Non-Executive Directors regularly visited clinical areas and were provided with a regular agenda slot to feedback from their visits.

¹² Watkins M, Jones R, Lindsey L & Sheaff R (2008) 'The clinical content of NHS trust board meetings: an initial exploration' *Journal of Nursing Management* 16: 707-715

10.2 Non Executive Director contribution

Contribution of individual Non-Executive Directors was analysed in the light of publicly-available biographical information. There was no obvious relationship between the extent and type of board meeting contribution and the occupational background of the NED. Similarly the length of time served on the Board (or, in the case of newly merged Trusts, predecessor bodies) did not influence the contribution made by individual Non-Executive Directors. These aspects were also examined in more detail in the Board Member survey (Phase 3).

In the Board meetings observed, the extent of discussion regarding clinical matters was dependent on questioning by the Non Executive Directors. Analysis across the 24 periods of observation (> 80 hours in total) revealed six types of questioning tactic used by Non-Executive Directors. These are presented at table 2 with sample question and prevalence in each Trust. These figures are included to illustrate the focus of questioning in the eight different Trusts hence have not been subjected to statistical testing.

Table 2 Questioning used by Non-Executive Directors during Board meetings by Trust

	Trust (n [%] questions)							
	A	B	C	D	E	F	G	H
Type of trust	PCT				FT		AT	
a. Supportive questioning (How have Out Patient clinics coped with increase in activity?)	5 [11]	0 [0]	0 [0]	6 [25]	7 [16]	1 [4]	3 [8]	1 [3]
b. Lessons learnt (Do we know why CDiff [infection] rates have improved so much?)	2 [4]	0 [0]	3 [9]	1 [3]	3 [7]	0 [0]	0 [0]	2 [6]
c. Contextual explanation [process] (Why are we focusing on hips and knees [waiting list initiative]?)	8 [18]	7 [27]	3 [9]	4 [17]	10 [23]	5 [20]	7 [18]	6 [18]
d. Seeking information (What is the average length of stay for all patients?)	14 [32]	8 [31]	7 [23]	5 [21]	15 [36]	8 [32]	7 [18]	9 [27]
e. Seeking strategy (How will you get up to target?)	11 [24]	7 [27]	10 [31]	4 [17]	7 [16]	10 [40]	9 [24]	4 [12]
f. Requesting further work (Can you examine why we have an increase in DNAs [patients who missed outpatient appointments]?)	5 [11]	4 [15]	9 [28]	4 [17]	1 [2]	1 [4]	12 [32]	11 [34]
TOTALS	45 [100]	26 [100]	32 [100]	24 [100]	43 [100]	25 [100]	38 [100]	33 [100]
Phase 1 clinical content of minutes (High/Low)	H	L	H but atypical	H	H	L	H	L

For the most part these discussions were not reported in the meeting minutes, with questions in category (f) most likely to be reported.

On the whole a greater portion of the questioning from Non-Executive Directors in the PCTs related to strategy. This may reflect the state of play at the time of data collection (see section 7); much of the discussion in the private part of PCT Board Meetings related to the dual role of commissioner and provider and, in particular, to the strategic intent of the Non-Executive Director role in sub-committee structures. Similarly in the Acute Trusts, both of which were preparing applications for Foundation Trust, the Non-Executive Directors were more likely to request further work in the Part 1 meetings.

Examples of the types of questions from Non-Executive Directors to Executive Directors and Chief Executive are provided below; data excerpts are identified by Trust/type of Trust and data source, e.g. [B/PCT obs]. Where necessary, additional text is inserted in square brackets to clarify meaning of the excerpt.

10.2.1 Supportive questioning

In one Trust, this included supportive, congratulatory comments such as *I am impressed with this Report and the extent of working with partners* [D/PCT obs]; however, the main thrust of this type of question was to ensure that the Board's decision-making was appropriate, for example:

Are you happy with the 4 hr target? [Board setting criteria for pilot work in the new Minor Injuries Unit] [A/PCT obs]

How are the problems with the NHS IT system affecting the staff at grassroots level? [E/FT obs]

Are you content with the length of time between an incident and the report; is it good enough? [F/FT obs]

10.2.2 Lessons learnt

Although these questions were the least likely to be asked (see table 2), they demonstrated a sense of 'target achievement' that was more than ticking boxes.

How have we managed to reduce both long term and short term sickness? [H/AT obs]

Do we know why our CDiff rates have improved so much? [E/FT obs]

The success of the sexual health model is to be applauded; is there a model here that we can also use for immunisation? [C/PCT obs]

10.2.3 Contextual explanation [process]

This category of questioning had two functions: firstly, to call the Executive Directors to account for previous decisions and, second, to improve the Non-Executive Directors understanding of complex clinical issues:

Why are we not achieving targets for out of hours diabetes services; is the target unrealistic?
[B/PCT obs]

Why is COPD not included in the top ten priorities? [World Class Commissioning indicators] [D/PCT obs]

It says here that we're running at 148% capacity; how?? [G/AT obs]

Why are we focusing on hips and knees? [waiting list initiative] [E/FT obs]

10.2.4 Seeking information

These questions were high in all Trusts, unsurprising given the state of transition outlined earlier, but perhaps for different reasons. Across all types of Trust there were three clear categories of information sought: clarity regarding the patient pathway:

Why are almost 50% patients waiting >31 days? [A/PCT obs]

Will the new informatics strategy improve co-ordination of diabetes management? [B/PCT obs]

governance issues:

What are the complaints about? We're far more interested in the nature of the complaints; we need more detail on this rather than the process to resolve them.
[G/AT obs]

When will we see improvement in the privacy and dignity performance indicators?
[D/PCT obs]

and cost implications of clinical practices:

What are the additional costs for pre-op screening of all patients? [for MRSA] [H/AT obs]

The risks and staffing are quite different for home and hospital births; are the tariffs different?
[home birth is more risky and staff intensive hence the tariff should be higher] [E/FT obs]

10.2.5 Seeking strategy

Similar to seeking information, questions posed by the Non-Executive directors regarding strategy had a different focus, depending on type of Trust;

How will we know that changes [resulting from a Health Care Commission report on one of the provider trusts] are being sustained? [B/PCT obs]

Who are we consulting with [with regard to regionalisation of stroke and trauma services]? [C/PCT obs]

How will we review this [Health Care Commission] rating during the year to ensure we're not in the same situation again? [F/FT obs]

How can we take this forward [problems with inpatient and outpatient waiting times] in relation to our Foundation Trust application? [H/AT obs]

10.2.6 Requesting further work

The type of further work requested by the Non-Executive Directors was related to the type of Trust, as illustrated by the following excerpts:

We can't see what the targets are and what the current baseline is; this needs different presentation. [in relation to WCC report] [A/PCT obs]

Can you please provide a separate report on orthopaedics each time and add it to the exception reporting. [F/FT obs]

Communication [with cancelled patients] is a weak area and needs improving [G/AT obs]

11. Phase 2 Findings: Comparison between observation and minutes

Minutes were reviewed for all twenty four meetings where observation took place. In addition, for each Trust one set of minutes was compared in detail with the observation notes. The level of detail recorded was variable, as noted in Phase 1 and there was no way of judging, from the minutes, the extent of discussion on any single issue. In one Board, the majority of questions raised by Non-Executive Directors were reflected in the minutes. In addition, some of the suggestions made by Non-Executive Directors are minuted as Board decisions. For example, during discussion regarding a local pilot project for self-directed care, one of the Non-Executive Directors stated that *"it is essential that there is no pressure for people to go down the self-directed route"*. This is reflected in the minutes as follows: *"The Board agreed that it was an important principle that people should have the choice whether or not they wish to participate in self-directed care"*. The desire to place on record the underpinning ethos of the Board in this manner was not reflected across all Trust Boards.

Of greater concern, in three trusts, comparison of observation fieldnotes and minutes revealed some discrepancies. There was no particular pattern to these differences, although there did appear to be some 'whitewashing' as illustrated at Box 3.

Box 3 Examples of whitewashing in Board Meeting minutes

Trust x: Comments during the meeting that Non-Executive Directors should be better informed about policy are not included in the minutes; instead a response asking Non-Executive Directors to indicate what kind of info they wanted was included.

Trust y: There were some notable omissions from the minutes including the possibility of recruiting staff from overseas and the need for nurses, GPs and health visitors to push vaccinations for MMR.

Trust z: During the meeting there were no items discussed under Any Other Business; the minutes state the Children and Young Persons' plan was discussed (this was not raised at all during the public meeting). When the minutes were ratified at the subsequent meeting there was no disagreement with the contents.

Board chairs generally made clear distinctions between matters for discussion and matters for decision. By contrast, at one Trust it was not clear at the meeting when decisions had been taken, although the minutes did indicate clear decision-making.

12. Phase 2 Findings: Functions of the Part 2 (Private) Board Meetings

During the private part of Board Meetings (Part 2), discussion tended to also focus on the adequacy (or otherwise) of documentation received from others. When Serious Untoward Incidents were discussed, there was a clear distinction between the detail of the incident (discussed in Part 2) and lessons learnt discussed in Part 1. On the whole, discussion at the private part of the meetings observed seemed to be under pinned by two principles:

1. Confidentiality – ensuring that confidential information isn't imparted in the public meeting;
2. Efficiency – the need to ensure the main board meeting focuses on the 'right' things.

In one Trust, the Part 2 meetings (held prior to Part 1) also emphasised the contribution of the Non Executive Directors, with the Chair requesting volunteers to lead questioning (of the Executive Directors) for substantive agenda items. There was no sense of directing/prompting the type of questions to be asked or any indication of 'stage managing'. Part 2 was dominated by questions about process, for example, the usefulness of reporting systems, information flow, how to ensure that the right people have the right information, particularly clinicians, and general matters of governance, for example:

"we need to work out how best to provide the Board with assurance that matters discussed in Part 2 are being progressed"

"we need an explicit section in the Board papers regarding risk and risk mitigation, to assure the public that the Board has been provided with evidence and discussed it"
[reference to a specific Serious Untoward Incident]

In contrast with other Boards observed, there was also discussion regarding governance issues in Part 1 meetings, as illustrated by the following excerpts;

NED: *"We need to report on progress with the recommendations from last year's report; these are not evident from this year's report"*

NED: *"What is the Board's response to Serious Untoward Incidents? We need to have processes for follow up, ensure that we can learn lessons and identify where there are trends in SUIs."* Chair: *"we also need to approve the stage at which the Health Care Commission would be brought in"*

13. Comparison between Phase 1 and Phase 2 findings

Phase 1 results demonstrated significantly more clinical ($p=0.029$) and non-clinical ($p<0.005$) items recorded in minutes of PCT Board Meetings than in Foundation or Acute (Non-Foundation) Board meetings; Phase 1 data also revealed a significantly greater number of items relating to *clinical service design and standards* in PCT Board Meetings ($p=0.028$). These differences were also evident in the Phase 2 data; in the eight Trusts observed, the public part of Board meetings was significantly longer in the PCTs than in Foundation or Acute (non-Foundation) Trusts. These results are perhaps not surprising given the commissioning function of PCTs. Table 1 highlights the match between the extent of clinical items identified in phase 1 data and the extent of NED questioning related to clinical items observed in Phase 2 [i.e. those that scored 'High' for clinical items in Phase 1 also had more questions identified in Phase 2 – see table 1].

SECTION C PHASE 3 Survey of Board Members

14. Questionnaire development

The questionnaire used for Phase 3 had three sections:

1. Areas of Interest: Board Members were asked to identify, in general, which areas of board discussion were of most or least interest to them personally. These areas of discussion were identical to those used in the coding instrument for Phase 1 and 2;
2. Relationships; Board members were asked to identify who they interacted with in relation to Corporate Governance, Clinical Governance and Finance;
3. Participation in Board Meetings: Board members were asked to identify how often they contributed to the areas of discussion at Q1 at the last Board meeting.

Demographic items were limited to type of Trust and Board role (Executive or Non-Executive Director). Executive Directors were also asked to provide their job title.

15. Phase 3 Sample and recruitment

There were 294 respondents (response rate 21%): 135 non executive directors and 159 executive directors.

- a. Thirty five of the 135 Non-Executive Directors identified additional roles that they held: 19 were chair and 8 vice chair of the Board, 7 were Chair of the Audit Committee, and one was Dean.
- b. There was a great range of titles for the Executive Directors (86 different titles for the 159) but when aggregated these were: Medical Director (31), Nursing (31), Chief Executive (22), Finance/Business (18), Corporate Affairs/Governance/Strategy/Planning/Quality (17), Operations (15), Other (9), Director of Public Health (8), Human Resources (8).

Our response rate was relatively low but response rate between Executive and Non-Executive Director was similar and we have no reason to believe that non-responders would answer differently. We found statistically significant differences between respondents by type of Trust or type of Board Member for some items. The extent of type II error is not known.

Phase 2 findings revealed that the roles of Non Executive and Executive Directors were considerably different; Phase 1 findings also revealed differences according to type of Trust. Hence for Phase 3 responses were analysed according to Director type and Trust type.

16. Phase 3 Findings:

16.1 Level of Interest in Board matters

The Acute Trusts are likely to be aspiring to Foundation Trust status hence, unsurprisingly, were more interested in areas for which Monitor would want high achievement i.e. clinical outcomes, activity levels and finance (see Table 3). Primary Care Trusts have a broad range of functions hence their lower interest in HR issues is not surprising.

Table 3 Level of Interest in items of discussion

	Percentages overall level of interest			Any differences?	
	Most interest	Some interest	Least interest	By Trust type	By Director type
● Service design and standards for patients (for example, range and volume of service provision, clinically related policies, screening and health promotion, cleanliness)	75	24	1		ED more interest p<0.001
● Clinical ethics and governance (for example, exceptional treatment policies, serious untoward incidents)	65	31	4		
● Clinical outcomes (for example, hospital acquired infection rates, achievement of clinical targets, waiting times, deaths)	88	12	0	Acute more interest p=0.001	
● Referral rates and volumes (for example, external referrals between different care providers or internally between departments; readmission rates)	42	48	10		ED more interest p=0.012
● Activity levels (for example, bed use, average length of stay, extra-contractual activity, cancelled operations, non attendance)	67	28	5	Acute more interest p<0.001	
● Evidence base for models of care/clinical procedures (for example, use of new drugs, changes in established practice, adoption of new evidence-based protocols or treatments)	37	44	19	Acute less interest p=0.001	ED more interest p<0.001
● NHS agendas (for example, Guidance for Department of Health, NHS targets, NICE, Healthcare Commission visits and external inspections/audits, Foundation Trust application, SHA commissioning)	13	38	49		
● Finance (for example, budgets and cost projections, financial targets, service level agreements, expenditure, cost savings)	25	26	49	Acute more interest p<0.001	NED least interest p=0.001
● Internal and external stakeholder relationships (for example, engagement with clinicians, other Trusts/PCTs, local authority, patient groups)	60	37	3		
● Human Resources (for example, incentives/rewards, sickness levels, staff recruitment & retention, grading)	48	43	9	Primary Care least interest p<0.001	
● Patient feedback (including complaints, positive feedback, patient satisfaction surveys)	83	16	1		
<p>Notes: ED = Executive director; NED = Non Executive Director Any differences?: probabilities from crosstabulations either 2X3 type of director or 3X3 type of trust and chi squared test. If no statistically significant difference, square left blank.</p>					

Whilst Executive Directors are, not surprisingly, more interested in service design, evidence base for practice and referral rates/volumes, it is encouraging that Non-Executive Directors express equal interest in areas of governance such as patient feedback/complaints, relationships with stakeholders, clinical ethics and clinical outcomes.

16.2 Consultation patterns

Consultation patterns reveal high levels of communication with the Board Chair and CEO in matters of clinical and corporate governance and finance (see Table 4). This pattern was similar across all types of Trust and across Executive and Non-Executive Directors. The nursing and medical directors were most likely to be consulted with regarding matters of clinical governance. However, findings also reveal consultation with Non-Executive Directors outside of formal Board meetings.

Table 4 Number of people, with different roles, who respondents consult with on governance and finance issues.

	Corporate governance	Clinical governance	Finance
Board Chair	247	151	177
CEO	259	214	229
Director of Finance	210	70	268
Director of Service Improvement	94	104	80
Medical Director	121	236	85
Director of Nursing	140	222	80
Director of Operations	135	146	138
Director of Human Resources	184	88	116
One or more other executive director	76	53	58
PEC Chair (PCTs only)	30	59	20
One or more NED	61	55	62
Two or more NED	61	49	59
Non-Board Member	37	26	20

16.3 contribution to last Board meeting

Respondents were asked to rate their contributions to specific types of agenda item/discussion at the last Board meeting (table 5). For the results 'by Director type', it is notable that Executive Directors were more likely to contribute to areas that have targets attached, especially those which are a mix of clinical and policy issues, for example, service design and standards, which are also areas with potential implications for risk management (accountability/liability). However, notable exceptions are clinical outcomes, referral rates and activity levels where there is no difference; although these areas are often 'target driven', they could perhaps be argued to be the 'raison d'être' of the NHS and therefore the main interest to all those who took up a position as Non-Executive Director.

Table 5 Self-rated contribution to last meeting and differences by type of Trust or type of Board member.

	Percentage contribution to last meeting			Any differences?	
	More than once	Once	Never Not discussed	By Trust type	By Director type
1. Service design and standards for patients (for example, range and volume of service provision, clinically related policies, screening and health promotion, cleanliness)	68	23	9		ED more likely p<0.001
2. Clinical ethics and governance (for example, exceptional treatment policies, serious untoward incidents)	44	35	21		
3. Clinical outcomes (for example, hospital acquired infection rates, achievement of clinical targets, waiting times, deaths)	59	32	9	Primary Care Trust less likely p=0.014	
4. Referral rates and volumes (for example, external referrals between different care providers or internally between departments; readmission rates)	27	32	41		
5. Activity levels (for example, bed use, average length of stay, extra-contractual activity, cancelled operations, non attendance)	40	37	23	Primary Care Trust less likely p<0.001	
6. Evidence base for models of care/clinical procedures (for example, use of new drugs, changes in established practice, adoption of new evidence-based protocols or treatments)	16	22	62		
7. NHS agendas (for example, Guidance for Department of Health, NHS targets, NICE, Healthcare Commission visits and external inspections/audits, Foundation Trust application, SHA commissioning)	51	34	15		
8. Finance (for example, budgets and cost projections, financial targets, service level agreements, expenditure, cost savings)	63	25	12	Primary Care Trust less likely p=0.032	NED more likely p<0.001
9. Internal and external stakeholder relationships (for example, engagement with clinicians, other Trusts/PCTs, local authority, patient groups)	50	35	15		
10. Human Resources (for example, incentives/rewards, sickness levels, staff recruitment & retention, grading)	31	36	33	Primary Care Trust less likely p<0.001	
11. Patient feedback (including complaints, positive feedback, patient satisfaction surveys)	31	42	27		

Any differences?: Probabilities from crosstabulations either 2X4 type of director or 3X4 type of trust and chi squared test. If no statistically significant difference square left blank.

Primary Care Trust Board members were less likely to have contributed to discussion regarding 'clinical outcomes', 'activity levels', 'finance' and 'human resources'. These findings are not surprising given the roles of different types of Trust and likelihood that Acute Trusts are aspiring to become Foundation Trusts. Primary care trusts have a far wider role than acute or foundation trusts and do not only provide care for patients/clients. This may explain the results in this table in terms of less contribution to discussion on clinically-related areas: their agenda at meetings is huge and very broad, as we have seen in Phase 2.

Non-Executive Directors were least interested in 'finance' but more likely to contribute to finance-related discussions; this suggests (perhaps reassuringly) that they see financial challenge as a key component of their role, regardless of their personal interest.

SECTION D DISCUSSION

The factors identified through the three phases of this study as affecting clinical focus in Board meetings can be grouped under:

- Board Dynamics;
- Public scrutiny
- Clinical information
- External influences

These are discussed below in the context of previous studies and grey literature.

17. Board Dynamics

Studying 'board process' has been identified as highly important for future corporate governance research¹³ but gaining access to corporate boardrooms across public, private and corporate sectors in and outside of health has proved extremely difficult if not virtually impossible for most researchers¹⁴. With the exception of the Part 2 meetings in two Trusts, permission was granted to access Board meetings in this study. Once granted the researchers were treated with utmost courtesy and Chairs showed interest in the study. Where there was difficulty accessing papers, this was because board papers were released late for all attendees.

The role of clinical directors, as reported by OPM¹⁵ could also be seen to be mirrored by our observation of Non-Executive Directors; some said little but where they were confident and tenacious, there was a greater depth and discussion of all issues, including clinical matters such as Serious Untoward Incidents. This type of role is also reflected in the 2009 Walker enquiry into Boards of banks; findings emphasised the need for Non-Executive Directors to be challenging rather than the equivalent of an 'old boys club' where decisions are 'rubber stamped' rather than properly examined.

18. Public Scrutiny

One stated reason for the change from NHS Trusts to Foundation Trusts is to increase both the discretion and the powers of NHS hospital management, in particular at Board level. Another is to 'give local stakeholders and the public opportunities to influence the overall stewardship of the organisation and its strategic development'¹⁶. The aim of Foundation

¹³ Peck E, Six P, Gulliver P, Towell D (2004) Why do we keep on meeting like this? The board as ritual in health and social care. *Health Services Management Research* 17 (2): 100-109

¹⁴ Leblanc, R. and M. S. Schwartz (2007). "The black box of board process: gaining access to a difficult subject." *Corporate Governance* 15(5): 843-851.

¹⁵ Burdett Trust (2006) *Who cares, wins: leadership and the business of caring*. London: Burdett Trust for Nursing

¹⁶ Department of Health (2007) *NHS Foundation Trusts: Governance*. http://www.dh.gov.uk/en/Healthcare/Secondarycare/NHSfoundationtrust/DH_4131785 Accessed 13 March 2009

Trusts is to make hospitals more accountable to local populations and free them from central control, giving the flexibility to improve service provision¹⁷ with more freedom to invest and disinvest and no requirement for financial reporting to 'the Centre'¹⁸. Boards of Directors are therefore mandated to open at least part of their meetings to the public. The two Foundation trust Boards observed in this study contrasted sharply in their approach to public consultation; in one the public part of the meeting last 45-90 minutes and no members of the public asked question whilst in the other the public part was longer and the PIF representative had a regular slot on the agenda.

Open access to the minutes from boards of directors' meetings gives valuable information to members of the public about organizational performance, finances and clinical outcomes, waiting times and success in meeting other DH clinical targets. They can also provide a record of the levels of involvement of non-executive directors who have a responsibility to question and challenge executive directors about the trust's management and performance. It could be argued that the lack of availability of minutes and lack of opportunity to attend boards of directors' meetings in some foundation trusts prevents members of the public from accessing valuable information about their local health provider and makes poor performance or underperformance less visible. This may or may not be deliberate, but it does not create the impression of an open, transparent organisation accountable to the public it serves.

Mid-Staffordshire Foundation Trust did not hold its board of directors' meetings in public and did not publish the minutes on the trust website from February 1 2008 to April 28 2009. One of the criticisms of the trust by the Healthcare Commission¹⁹ was that its management board did not routinely discuss the quality of care. It could be hypothesised that public scrutiny might influence the way in which trust boards conduct and report on boards of directors' meetings. The move towards holding board meetings in private and the lack of availability of minutes from these meetings is not easy to defend. While it is not clear whether this shift is intentional, these results have highlighted a reduced transparency and openness that organisations need to redress if they are to retain public confidence

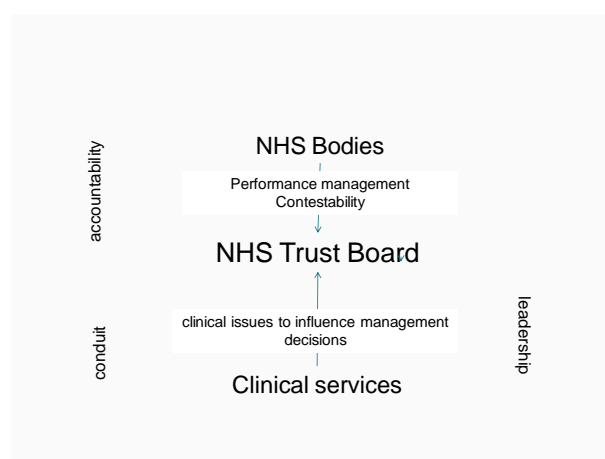
From the results of this study the authors recommend that foundation trusts ensure that minutes of boards of directors' meetings are posted in easily accessible places on their websites, even if their meetings are not held in public. This will demonstrate transparency and enable the public to see what is happening in their local trust.

¹⁷ Boyle, S. (2005) *What foundation trusts mean for the NHS*. LSE Health and Social Care Discussion Paper Number 18. The London School of Economics and Political Science.
http://www.lse.ac.uk/collections/PSSRU/pdf/DP18_2005.pdf Accessed 13 March 2009

¹⁸ Marini G, Miraldo M, Jacobs R, Goddard M (2007) Foundation Trusts in the NHS: does more freedom make a difference? *Health Policy Matters* Issue 13 Accessible via www.york.ac.uk/healthsciences/pubs/hpindex.htm (accessed 13 March 2009)

¹⁹ Healthcare Commission (2009) *Investigation into Mid Staffordshire NHS Foundation Trust*. Healthcare Commission, London.

Figure 3 intended relationships between NHS bodies, NHS Boards and clinical services



19. Clinical Information

NHS Trust Boards are required to exercise effective governance internally over the provision and quality of patient care in their organisation; they are also intended to provide a conduit for clinical interests and issues to influence managerial decisions (see Figure 3). Our data suggest that the manner in which this is enacted is hugely variable across trusts. Policy documents also assume that these Trust Boards are responsible for improving access to and the quality of hospital clinical care, and as one channel (among others) for representing patients' interests in these matters²⁰. NHS Trusts have therefore been the venue for attempts to implement various moves towards target-setting, stronger performance management and those aspects of clinical governance which emphasise evidence-based practice. Further, the implementation of national standards of care (e.g. National Service Frameworks) presupposes that Trust Boards can exercise a strong leadership role in the clinical domain.

Board control is the most important formal governance mechanism in such a hierarchy as an NHS Trust. A Board's managerial decisions are communicated to those lower down an organisation hierarchy, who then comply because their behaviour in response to managerial decisions is:

1. incentivised i.e. the Board has power to 'hire and fire', promote staff, vary pay and material conditions of work.
2. legitimated, through ideologies, value-systems and organisational 'culture'.
3. scrutinised by management, creating a mentality of habitual self-control ('governmentality'²¹).

NHS hospital performance data indicate substantial variations, and in some cases substantial implementation deficits, in regard to (for instance) access times, rate of hospital associated infections, success of preventive health initiatives and cost control. Performance management theorists attribute such variations at least partly to differences in managerial skill and

²⁰ Department of Health (DH) (2005) *Short Guide to NHS Foundation Trusts* London, DH

²¹ Foucault M (2004) *Naissance de la biopolitique: Cours au Collège de France (1978-1979)* Paris: Gallimard & Seuil.

processes, ultimately to those occurring at the top of the managerial hierarchy of (in the present case) NHS Trusts. The Kennedy report²² on a failure in NHS clinical management is perhaps the most detailed recent example of an analysis on these lines. A recent review of nurse executives also reported that nursing leaders within Trusts often lack the skills, confidence and opportunity to ensure clinical and patient care issues are adequately discussed at board level²³. Our data demonstrate considerable variation in discussion of clinical information, at least through formal Board mechanisms. As discussed above, this was highly dependent on the ability and willingness of the Non-Executives to provide appropriate challenge and of the chair to ensure that agenda items were handled appropriately and clinical matters given sufficient 'air time'.

20. External Influences

UK governments since 1990 have favoured the 'public firm' model for the organisational structure and management practices of public service providers, modelled on what policy-makers believe the equivalent commercial organisational structures and processes to be, and capable of implementing 'new public management' ideas and managerial practices (among others, see Ferlie et al²⁴). One consequence has been the creation of a distinctive Board membership and structure for NHS hospitals, i.e. NHS Self-Governing Trusts and, since 2006, Foundation Trusts. NHS Trust Boards, and in Foundation Trusts the Board of Directors, are held accountable to higher NHS bodies both by 'performance management' (line management control, by the Board of Governors in the case of Foundation Trusts) and 'contestability' (commissioners can substitute other providers). These two drivers were evident in all three phases of data collected for this study:

- a) review of minutes across 105 Trusts revealed that PCTs, wearing mainly commissioner 'hats' recorded significantly more items related to service design and Foundation trusts recorded significantly more items related to activity levels.
- b) observation of meetings revealed that performance management contestability were consistently on the agenda (overtly or covertly) and often triggered vigorous debate;
- c) survey of Board members demonstrated that Executive Directors were significantly more interested in items related to performance management such as referrals rates and service standards.

²² Anon (2001) *The Inquiry into the management of care of children receiving complex heart surgery at the Bristol Royal Infirmary 1984-1995. Learning from Bristol: the Report of the Public Enquiry into children's heart surgery and the Bristol Royal Infirmary 1984-1995. Cm5207* London: HMSO

²³ Burdett Trust (2006) *Who cares, wins: leadership and the business of caring*. London: Burdett Trust & OPM

²⁴ Ferlie E; Ashburner L; Fitzgerald L & Pettigrew A (1996) *The New Public Management in Action* Oxford: Oxford UP.

SUMMARY

Our data demonstrate that NHS Trust Boards are no different from other Boards; the quality of challenge depends on characteristics of the individual members, from Chair to Non-Executive Director, and the quality of consumer [patient] representation. In order to fulfil goals of robust stewardship and sound governance, Trusts Chief Executives and Chairs should pay attention to: preparation for role of Non-Executive Director, clarification of governance processes and clear processes for public scrutiny and public involvement. We observed many examples of good practice during the process of undertaking this study, many of which are contained in this report; however, findings reveal that there is still much progress to be made.

Appendix 1 Phase 1 Coding criteria

Defining an 'item'?

- An 'item' is a discrete issue or topic raised by a Board member. It is defined by content, i.e. by having a relatively clearly bounded content, distinct from preceding and subsequent contents of discussion. In Board minutes, an item typically (but not by definition) concerns one heading on the agenda, is around 8-10 rows long and deals with single topic. However items may be longer and more complex.
- Hence, one 'item' can satisfy more than one of the category headings below
- Repetitions of the same point count as 1 item only
- Opposing viewpoints on the same issue count as 1 item only
- If coding by observation of meeting, mark items stated to be 'not for minuting'. They will be ignored when observational data are merged with data extracted from printed minutes.

Coding 'who raised' or 'who discussed'

- ED-Non-Clinician
- ED-Clinician ('clinician' means any occupations providing health care, but not 'hotel' services, directly to patients)
- NED-Non-Clinician
- NED-Clinician
- Member of public
- Invitee other than the above

Categories of meeting contents:

CLINICAL

'Clinical' is defined as 'concerning the direct provision to patients of physical or psychological care or diagnoses' (not the organisation thereof KEY!!).

- Service design & standards
 - Protected meal times
 - Range and volume of services
 - In-patient nutrition
 - Medical etc. records
 - Risk management
 - Quality / risk assurance framework
 - Visiting policy
 - Length of stay
 - On-call arrangements
 - Clinical equipment policy (including implants, consumables)
 - Equipment-related clinical outcomes (e.g. problems with implants, lifespan of these, replacements)
 - Discharge policy
 - Untoward incidents
 - Information provided to patients
 - Prescribing
 - Health promotion

- Clinical ethics & governance (directly related to a specific clinical issue)
- Clinical outcomes
 - Deaths
 - Unplanned re-admissions
 - Hospital-acquired infection
 - Public Health data (evidence of local need)
 - Clinical targets (Ca etc.)
 - Waiting times, for example in ED or on waiting list (because used as a clinical target by DH)
- Referral routes and volumes
 - 1ary to 2ary care
 - 2ary to 3ary care
 - Into A&E
 - Internally between hospital departments / clinics /sites / specialties
 - 2ary to CHS
 - Liaison psychiatry
 - Policy-led referrals to ISTC
 - OH activity (internally)
 - Information provided to referrers (e.g. GPs)
 - Re/admissions
 - Discharges
- Activity levels
 - Utilisation rates
 - Bed use
 - ALoS
 - Current case-mix
 - Predicting future case-mix
- Evidence-basing of
 - models of care
 - clinical procedures

NON-CLINICAL (i.e. all else)

General

- Board's own administrative processes (observed)
- Board's own administrative procedures (formal)
- Public membership of Board (FT)
- Governors' induction programme
- Board consultations
- Meeting frequency and timings
- Reporting to Board:
 - arrangements for subordinate management, committees, boards, directorates
 - Board orders / receives reports
- Role of Non-Executive Directors
- Freedom of Information queries

NHS Agendas

- Own foundation trust application

- NHS Targets, star ratings (including Better Payment Practice Code)
- Imposed external management consultants
- Health-related policy developments outside the health sector(including health & safety)
- Independent sector provision (ISTCs etc.)
- Guidance from NICE, DH etc.
- Payment by results tariffs
- Health and safety policy
- External validations / inspections
- Recommended managerial practices
- EU policy
- SHA commissioning

Finance

- Current and prospective budget out-turns
- SHA budgets and cost projections, including of reference costs
- Inflation
- Service Level Agreements
- Billing, cash-flow, under / over-trading
- Cost-cuts, savings, 'efficiencies'
- Capital planning
- Sales of land, buildings, equipment
- External financial audit
- External contracts / negotiations (post hoc reporting of, as distinct from *relationship with suppliers* see below)
- Costs of supplies
- Procurement methodology

Organisational

- 'Clinician engagement'
- Trust's consumer research findings/ consultation processes
- **Relationship with** patient forum and other patient-representative bodies/ stakeholders
- Planning cycle and processes including new build
- Organisational structure
 - Roles and functions of specific posts
 - Provision of management services
 - Security arrangements
- Informatics
 - Clinical coding
 - Data availability/ receipt of data
- Relationship with PCT, SHA, social services, county councils, private partnerships etc
 - Inter-organisational agreements, policies, disputes
- External accreditations and awards – including clinical accreditations and NHSLA
- Internal monitoring of activities and outputs
 - Clinical governance
 - Corporate governance and corporate risk
 - Monitoring
- Gaming to satisfy targets
- Organisational and local health economy boundaries

- PCT mergers
- Relationship with suppliers (procurement) including discussion about who to engage for services

Staffing

- HR
 - Incentive and rewards policy, terms and conditions of employment
 - Staff training
 - Sickness levels, stress, turnover
 - Staff occupational health
- Staffing levels
- Holidays
- Cover for leave, sickness etc.
- Temporary staff
- Recruitment
- Skill-mix, substitution
- Staff regrading

Patient Feedback (as distinct from relationship with PPIF etc)

- Complaints
- Positive feedback
- Systematic collection of patient views
 - Consumer research reports

Alerts & principles

Be aware of repetitions of the same point that may be coded twice in error

Check all double-coded points. Try not to double-code unless the item is making two distinct points. For example, if the minutes refer to health policies that are later reported on, code this singly as 'NHS agenda' rather than both 'NHS agenda' (because of the policy) and 'organisational' (because of the report). When coding an item which has an *impact* on another area (e.g. some aspect of the NHS agenda which impacts on the organisation) code according to the driver/originator.

Avoid over-interpretation when analysing data – try to avoid reading intentions/meaning etc into superficial data as assumptions can be inaccurate.

Check context of words/ codes, e.g. 'policy' – is this internal within the organisation, or external, e.g. an NHS agenda. Beware of confusing or mixed message phrases, e.g. 'outcome measurement' could be either clinical or organisational dependant on the context.

Only code 'outcomes' as clinical if they are related to specific clinical issues (for example this phrase may be used in relation to audit processes or outcomes of target-setting).

Code complaints as non-clinical unless specifically linked to a clinical issue.

Statements of compliance with targets etc should always be coded as non-clinical (organisational or NHS agenda, dependant on context) even if about clinical targets.

Any discussion of the roles of non-executive directors should be classified as 'General' (i.e. Board function and process).

Don't code minutes of closed sessions from publicly available minutes – these are insufficient to gain meaningful data.

Be aware of clinical or management jargon in minutes that may be misunderstood (e.g. 'outliers' refers to patients who are not in the correct wards, such as a surgical patient in a medical bed or vice-versa; 'performance monitoring' is used for clinical governance or human resources issues and is not a clinical item).

Beware of rater fatigue. Signs to look for:

- unusually small number of codes per page
- over-arching trends that occur
- constantly recurring categories in a large section of text
- not reading text thoroughly/lack of concentration.

Take a break and avoid prolonged periods of analysis or analysing when tired.

Mark up any areas you are unsure about or those that are unclear for discussion with other raters.

Revised 8th February 2008

Appendix 2 Conference & Publication Abstracts

1. Clinical focus at Board level in English NHS Trusts (Endacott, Sheaff, Jones & Woodward)
European Health Management Association conference. Athens, 23-26 June 2008

Abstract

Background: UK governments since 1990 have favoured the 'public firm' model for the organisational structure and management practices of public service providers. One consequence has been the creation of a distinctive Board membership and structure for NHS hospitals. NHS Trust Boards are held accountable to higher NHS bodies both by performance management and contestability. Trust Boards are also intended to provide a conduit for clinical issues to influence managerial decisions. Further, the implementation of national standards of care (e.g. National Service Frameworks) presupposes that Trust Boards can exercise a strong leadership role in the clinical domain.

The **aims of the study** were to:

1. refine methods for measuring the concept of clinical focus
2. examine the effects of differences in Trust Board membership on clinical focus
3. examine relationships between clinical focus and organisational culture
4. examine relationships between clinical focus and service outcomes

Methods: Study aims were addressed through a two phase design:

Phase 1: analysis of publicly available data (Board meeting minutes, biographies of Board members, n= 92 Boards)

Phase2: Observation during Board meetings (n=8 Boards)

Results and discussion: There was considerable variation in the ease with which 'publicly available' data could be accessed from the Trust websites. Distinction was made during analysis between clinical focus arising from clinical and non-clinical agenda items. The processes by which clinical matters were raised at the board varied between Trusts, specifically between acute (hospital) Trusts with varying clinical governance processes and primary care Trusts that commonly had a formal committee process to debate and manage clinical issues. Hence the Board role in governing clinical matters could be quite different. The next phase of the study will comprise a survey of Board members, analysis of publicly available service outcome data and organisational measures to examine relationships between Board membership, clinical focus, organisational culture and service outcomes (n=92 Boards).

2. Woodward V, Endacott R, Sheaff R, Jones R. (2009) Locating corporate information from NHS Trusts: has Foundation Trust status led to decreased transparency? *Nursing Standard* 23(42): 35-37

Summary

Foundation Trusts have boards of directors that are responsible for the day-to-day running of the organisation, forward planning and strategy development. Unlike non-foundation trusts and primary care trusts (PCTs), foundation trusts are not obliged to hold boards of directors meetings in public. This article describes the online availability and accessibility of the minutes of such meetings in a number of foundations trusts, non-foundation trusts and PCTs. The implications for transparency in the NHS are also discussed.