

EXPLORING THE FACTORS THAT MEASURE THE PERFORMANCE OF
BOARDS OF DIRECTORS OF NHS FOUNDATION TRUSTS AND THE
ASSOCIATION BETWEEN BOARD AND ORGANISATIONAL PERFORMANCE

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by

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ABSTRACT

The purpose of this study was to explore the factors that measure the performance of boards of directors ('the board') of NHS foundation trusts and the association between board and organisational performance. The study investigated six dimensions of effective board performance - contextual, educational, interpersonal, analytical, political and strategic - as suggested by Chait, Holland and Taylor (1993) from their extensive research involving nonprofit boards, including hospital boards, in the USA.

A total of 79 board members (42 executive and 37 non-executive directors) representing 21 foundation trusts (organisational response rate 33.9%) responded to a Board Self-Assessment Questionnaire (BSAQ) incorporating the six dimensions of board performance. Factor analysis showed that the six dimensions were similar for NHS foundation trusts as for nonprofit boards in the USA and, further, that the dimensions can be consolidated into a higher level construct of board performance. This suggests a cohesive and collaborative approach to board functioning. The unitary nature of foundation trusts boards, i.e. comprising executive and non-executive directors, was not found to significantly affect the measurement of board performance.

The perception of around 80% of respondents was that their boards influenced organisational performance to a 'large' or 'very large' extent. Foundation trust performance was objectively assessed using publicly available data and the association between board performance, as quantified by the overall BSAQ score, and financial performance, in terms of surplus, showed a strong positive correlation ($r=.66$, $p=.001$). A particularly strong correlation was found between strategic BSAQ scores and financial performance ($r=.73$, $p=.000$), suggesting that boards take their strategic

responsibilities for financial governance seriously. Strong and statistically significant correlations were also found between the political dimension of board performance and a range of non-financial organisational performance indicators relating to staff satisfaction.

The findings from this study suggest that better performing boards of directors are associated with higher performing foundation trusts. Attending to board development issues using validated tools such as the Board Self-Assessment Questionnaire (BSAQ) should, therefore, result in improvements in foundation trust board and organisational performance.

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CHAPTER 1 - INTRODUCTION

1.1 Corporate governance in the NHS in England

Some 1.3 million people work for the National Health Service (NHS) in England (NHS Careers, 2004), making it the fifth largest employing organisation in the world (Mathieson, 2005). The NHS provides essential treatment and care, free of charge, to the entire population of some 49 million. Hospitals alone deal with around 9 million patients every year. Total public spending on the NHS in England will, by 2008, be approaching £100 billion per year, equivalent to 9.4% of GDP. (HM Treasury, 2002).

Aneurin Bevan created the NHS in 1948 on the principle that if a bedpan dropped in a hospital corridor, the reverberations should echo in Whitehall, home of the Department of Health and its government health ministers. Command and control was the order of the day. The result, according to Wilby (2007) was “the most politicised of all government services.” In 1990, however, the government started to give local NHS hospitals more control over their affairs. NHS trusts were established under Section 5 of the National Health Service and Community Care Act 1990 as corporate legal entities, with their own governing board of directors and a statutory financial duty to ‘break even’ annually. The board of directors was based on the Anglo-Saxon private sector unitary board model, comprising a combination of executive and non-executive directors, which predominates in UK and US business (Chambers, 2006).

With the introduction of NHS Trusts came a drive by the Department of Health to improve corporate governance in the NHS through adoption of many of the

recommendations of the private sector Cadbury Committee report on the financial aspects of corporate governance (Cadbury, 1992). Over the nineties, the Department of Health went on to adopt, for the NHS, successive private sector corporate governance guidance. This culminated with the introduction of the NHS controls assurance project in 1999 (Department of Health, 1999a), which was concerned with implementing the requirements of the Turnbull Committee report on internal control (see Financial Reporting Council, 2006). The NHS controls assurance project was verbally described by the then Director of Finance and Performance for the NHS at the Department of Health as “the final piece of the NHS corporate governance jigsaw.”

The pursuit of good governance in the NHS had become, by the new millenium, a key priority. In part, this was due to what were seen as an increasing number of governance-related failures (HFMA, 2006). In particular, over the past 15 years there had been a number of high profile organisational failures relating to clinical and reputational issues. Arguably the greatest example was that relating to the management of care of children receiving complex heart surgery at Bristol Royal Infirmary from 1984-1995, which resulted in a major public inquiry (Bristol, 2001). It also resulted in the development of ‘clinical governance’ as an attempt, based on the principles of good corporate governance, to improve the safety and quality of care in the NHS (Scally and Donaldson, 1998; Department of Health 1999b). Clinical governance became the essential underpinning approach for NHS chief executives to meet their ‘statutory duty of quality’ introduced under section 8 of the 1999 Health Act. This has translated into a board-wide responsibility to assure itself in relation to the safety and quality of patient care (Stanton, 2006).

However, the pursuit of good governance by the Department of Health was not just about trying to minimise organisational failure. It was also about improving the performance of individual NHS organisations, and the NHS as a whole. With their ultimate accountability for everything that happens in their organisation, boards were seen to play a key role in ensuring performance improvement and overall organisational success. According to Stephen Dorrell, then Secretary of State for Health, “The effectiveness of the NHS in delivering health care and improving the health of the nation depends essentially upon the direction given by boards of its Trusts and Authorities.” (Institute of Directors, 1996). And so, for the first time in the history of the NHS, a Secretary of State clearly and firmly linked board and organisational performance. Also in 1996, writing in the *Journal of Management in Medicine*, Deffenbaugh (1996) reinforced the need for effective NHS boards in order to deliver benefits for patients.

The interest in improving the governance of NHS organisations in England continued into the new millennium. In 2003 the NHS Appointments Commission, an ‘arms length body’ established to appoint non-executive directors, including chairs, to NHS organisations, published, in association with the Department of Health, comprehensive guidance on governance in the NHS for board members (NHS Appointments Commission, 2003). This guidance sought to bring together many strands of governance which, by 2003, had developed across the NHS (Emslie et al., 2006). It also signalled plans to develop an ‘integrated’ approach to governance. The ‘Integrated Governance Handbook’ for executive and non-executive directors in the NHS was duly published in February 2006 (Department of Health, 2006).

Under the Department of Health's Standards for Better Health (2004), implementing a system of 'integrated governance' is a key requirement for all NHS organisations. Integrated governance is viewed by the Department of Health (2006) as "a means by which we pull together all the competing pressures on Boards and their supporting structures, to enable good governance." The guidance provides NHS organisations with a range of supporting tools to help them implement the concept of integrated governance. Unfortunately, however, and despite the recognition of the key role of boards of directors in improving performance in the NHS, there are no robust, validated tools contained in the guidance to help identify and rectify poor board performance.

1.2 The development of NHS foundation trusts

The introduction, on 1 April 2004, of the first NHS foundation trusts was a particularly significant initiative by the government to free NHS organisations from the grip of government control and improve performance and local accountability. To-date, not everyone agrees that performance and accountability has improved in practice (Marini, et al., 2007; Allen, 2006), but it is probably too early in the stage of development of foundation trusts to fully assess.

NHS foundation trusts operate under a different financial regime from other NHS organisations (Monitor, 2007). They are, essentially, nonprofit businesses – 'public benefit corporations' - operating within the framework of values of the NHS. Unlike their non-foundation siblings, they are not under a statutory duty to break even every year. Instead, they can generate a surplus, which they can re-invest to improve services

for patients. They can also incur a deficit, although the regulatory framework requires an NHS foundation trust to demonstrate financial viability over the medium term.

In the corporate world, boards are increasingly portrayed in the normative and academic literature as “an increasingly active body seen as ultimately responsible for corporate success.” (Nicholson and Kiel, 2004). In the NHS, and particularly with the advent of foundation trusts, boards are certainly seen as ultimately responsible for organisational success, and failure. However, whereas with non-foundation trust NHS organisations there is a ‘safety net’ above the board in the form of Strategic Health Authorities and, ultimately, the Department of Health, who can provide financial support if necessary, with foundation trusts the proverbial buck stops with the board of directors.

Consequently, if foundation trusts are to be successful they need to perform. And for board-governed organisations to perform, they need effective, or high performing boards (e.g. Garrett, 1997; Pointer and Orlikoff, 1999; Pointer and Orlikoff, 2002; Bevington, et al., 2005a).

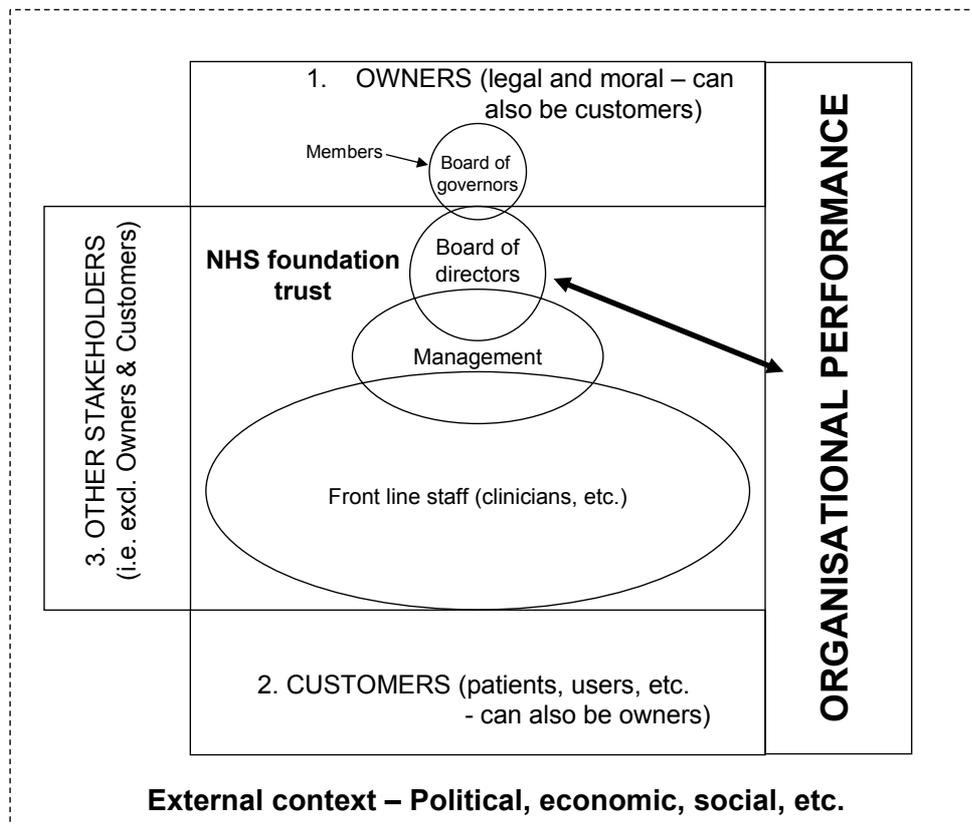
In 2006, Monitor, the independent regulator of NHS foundation trusts, issued its own voluntary code of governance for foundation trusts (Monitor, 2006). Based on the UK Combined Code of Corporate Governance (Financial Reporting Council, 2006), the code sets out a range of governance structure, process and reporting, or disclosure requirements. Principle A.1 of the code states that “Every NHS foundation trust should be headed by an effective board of directors, since the board is collectively responsible for the exercise of the powers and the performance of the NHS foundation trust.” Again, we see board and organisational performance being linked. But as Hawthorne et al.

(2005, p2) state, “the question that must be asked is: Does good governance actually link to better organizational performance? Otherwise, why all the effort?”

It is worthwhile briefly pondering this question in relation to the governance and performance context for NHS foundation trusts, which is depicted, conceptually, in Figure 1.1. The reality is that the delivery of modern healthcare to patients is, in many cases, quite a complex undertaking. As West (2001) states, “Understanding how the organisation and management of hospitals affects the quality of patient care is no mean task.....we do not yet have a theory that reflects the complexity of the relationships involved.”

Conceptually, however, substantially freed from direct government control, boards of directors, who are ultimately accountable for the organisation, report to a ‘board of governors’ elected by the trust’s membership. The board of governors, in addition to the elected membership, contains representatives of key stakeholder groups. The board of governors, in reality, is essentially a ‘council of members’, similar, in the private sector, to a shareholder’s council. It has very little authority. Most of the authority to govern rests with the board of directors. It is the board of directors who, in governance terms, are the key to organisational performance. But, given the impact of wider management, front-line staff and factors relating to the external context, to what extent can the board truly positively impact organisational performance? (Lockhard, 2006). In addition, given the unitary nature of the board, i.e. comprising both executive and non-executive directors, is there a difference in perception of board performance between the executives and non-executives that might hold the board back from developing its full potential? (Deffenbaugh, 1996; NHS Confederation, 2005).

Figure 1.1 – The governance and performance context for NHS foundation trusts



1.3 Linking board to organisational performance

Despite NHS boards having been around since 1990, there appears to be no published studies relating to any significant, systematic, empirical evaluation of NHS board and organisational performance. This study appears to be a first. Inherent in this study is the belief that boards make a difference and the difference, as well as the level of board performance that the difference relates to, can be quantified.

According to Sir Nigel Crisp, former Chief Executive of the NHS, “Boards that make a difference set clear direction, keep a relentless grip on performance, set stretching goals for their organisation and pay real attention to their stakeholders. They expect and they

get disciplined management at all levels in their organisation, staff are confident because they know the place is well run, patients walking into the institution see that someone cares for their needs and local people know what's happening with their health service, and people want to come and work for them.” (Emslie, 2005, p.2).

Anecdote is fine, but to quantifiably link board and organisational performance we must first measure the two variables. In the NHS a myriad different performance indicators relating to organisational performance exist. But there are no robust, empirically validated tools to measure board performance. This will be considered in the next chapter, but suffice to say that a suitable instrument for this study had to be sourced, based on literature review, in the USA non profit sector. The instrument selected was the Board Self-Assessment Questionnaire (Chait et al., 1993), which was developed based on extensive research with nonprofit boards, including hospitals, in the USA. The BSAQ attempts to measure board performance, or competency, in relation to six key dimensions - contextual, educational, interpersonal, analytical, political and strategic (Appendix 1). Thus, this research project looks to establishing the association between board and organisational performance in NHS foundation trusts using the BSAQ as the key instrument for measuring board performance.

1.4 Principal research questions

Given the foregoing, together with a desire, as an integral part of this study, to establish whether in a unitary board there are any significant differences between executive and

non-executive directors in relation to measurement of board performance, the following principal research questions were posed:

1. Are the six dimensions of effective board performance suggested for nonprofit boards in the USA by Chait, Holland and Taylor (1993) similar in the context of NHS foundation trust boards of directors?
2. Given the unitary nature of foundation trust boards of directors, is there a difference in perception of board performance between executive and non-executive directors?
3. Is there an association between board performance, as measured using the BSAQ instrument, and organisational performance in NHS foundation trusts, as defined by publicly available data providing objective measures of financial and non-financial performance?

In addition, a number of supporting questions were posed and these are outlined in section 4.1.

CHAPTER 2 – LITERATURE REVIEW

2.1 Deficiencies in NHS board and organisational performance research

There is a paucity of published studies describing empirical research involving NHS organisations and their boards. There appear to be no published studies describing the relationship between board and organisational performance in the NHS.

Cray (1994) conducted interviews with chief executives and chairmen (sic) of NHS trusts in the former South East Thames Regional Health Authority area. She concluded that the following four key issues needed to be addressed: 1) Clarification of the role of the board and agreement on success criteria; 2) How to maximise the role and contribution of the non-executives; 3) Spending time building relationships between board members; and 4) Setting aside time to review board performance against success criteria.

The work of Bevington et al. (2005a; 2005b) in many ways complements the issues that Cray (1994) found. Bevington et al. also usefully describe personal experience, anecdote and reviews of a subset of literature on board work outside of healthcare as described by other authors, most notably Sonnenfeld (2002) and Nadler (2004).

Bevington et al. conclude (p.75) that “The key...to delivering high performance at board level lies as much in behaviours and relationships as it does in structures and processes. In particular, constructive challenge and trust are two major building blocks in great boards.”

The NHS Confederation (2005) appears to have undertaken the only published systematic review of board effectiveness in the NHS, which builds on the work of Bevington et al. (2005a; 2005b). From an academic perspective, however, the study gives the appearance of being somewhat lacking in rigour. It involved observing one board meeting of each of 12 randomly selected NHS organisations and then conducting semi-structured interviews with a “number” of executive and non-executive board members. The interviews were “designed to explore what board members believed are the characteristics of an effective board and how, in practice, boards lived up to their expectations.” (NHS Confederation, 2005, p6). But the results did not appear to advance knowledge in this area. Their principal finding was the identification of four main characteristics that interviewees felt made for an effective board. These were strategic decision-making; trust and cohesion; constructive challenge; and effective board processes. To be fair to the NHS Confederation, by their own admission they were not pursuing an academic research study. They were simply concerned to stimulate debate on the subject of board effectiveness and to “provide pointers where more detailed academic research could be focussed.”

Interestingly, evaluating the performance, or effectiveness, of NHS boards of directors is not a new concept. In April 1996 the Institute of Directors published good practice criteria for NHS boards (Institute of Directors, 1996). These included specific criteria for “Building an effective board.” And, more recently, the NHS Institute for Innovation and Improvement produced a self-assessment ‘Chair and Board Performance Review Tool’ for boards (Bevington et al., 2005a). However, neither of these has been subjected to any systematic validation studies. Thus, they should be viewed, as Holland (1991,

p.35) suggests in relation to other board self-assessment tools, as “springboards for discussion and not as valid measures of actual performance.”

Given that the NHS is one of the largest organisations in the world, and one in which boards of NHS organisations are reputed and, indeed, expected to make a difference (IoD, 1996; Emslie, 2005) and bring benefits to patients (Deffenbaugh, 1996), it is, perhaps, surprising the apparent lack of research endeavour into board and organisational performance matters.

There is, however, a significant body of literature on board and organisational performance outside of the NHS. Unfortunately, the word limit for this dissertation plus the desire to principally focus on research data and findings necessarily limited the breadth of account of the literature reviewed for this study. The bibliography therefore identifies key additional literature consulted. In addition, chapters 4 and 5 include, where appropriate, references to or comparisons with additional literature reviewed.

2.2 Review of non-NHS board and organisational performance literature

This section briefly reviews key literature from the wider nonprofit (including healthcare) and private sector corporate governance arenas, particularly in the USA, in relation to three key areas: 1) the characteristics of high performing boards; 2) linking board and organisational performance; and 3) measuring board performance in nonprofit organisations.

i) The characteristics of high performing boards

Herman et al. (1997, p. 374) state that “the major challenge in the study of board effectiveness is the lack of criteria for defining and measuring board effectiveness.”

This may have been a truism in 1997, but in 2007, and looking back on recent research, we find the literature surrounding boards is replete with suggestions for characterising and measuring board performance. Some suggestions are based principally on individual experience and anecdote (e.g. Garrett, 1997; Davies, 1999; Pointer and Orlikoff, 1999 & 2002; Kiel and Nicholson, 2003; Charan, 2005). Others are based on the results of systematic empirical studies (e.g. Sofaer et al., 1991; Bradshaw, 1992; Gill et al., 2005). Yet others are based on systematic reviews of individual experience and anecdote (e.g. Cowan, 2004; Adams, 2005). And others still are based on suggestions derived from relevant theories, such as agency, resource dependency, stewardship, stakeholder, and group/decision process theory (Miller-Millesen, 2003; Brown, 2005; Roberts and Young, 2005).

Nicholson and Kiel (2004, p453), writing about boards of directors in a corporate context, suggest that “An effective board is one that can successfully execute the role set required of it.” They argue that “a sophisticated understanding of roles and the interplay between the roles and the [organisation’s] environment is central to any assessment of board effectiveness.” According to Letendre (2004, p. 104) the key to effective boards of directors is “Independent, intrepid, informed, diverse (in background and expertise) directors willing to speak up when concerned or in doubt and to challenge management and each other are crucial to healthy and constructive boardroom dynamics and to effective corporate governance.” Thus, getting the board culture right

is, apparently, crucial. Bevington et al. (2005a; 2005b) see behaviours and relationships, or 'cultural issues', as the driving factors of board effectiveness. This is supported by Holland et al. (1993) who stress that the actions of boards emerge from board culture. Holland et al. (1993) further stress that board development efforts that don't take cultural or behavioural factors directly into account are likely to produce only superficial and short-term changes in board performance.

ii) Linking board and organisational performance

Establishing the association between board and organisational performance is the *sine qua non* of corporate governance research. Lockhart (2005) believes that after over two decades of governance research "we are little the wiser in determining whether or not there is some relationship between governance and the organisation's performance." He argues the difficulty of establishing causality between boards and organisational performance, citing "the entire process of management, its performance and outcomes, all of the organisation's internal processes, competencies and resources [and].....the external environment" as factors that, essentially, 'get in the way.' "Organisational performance", he says, "...results from some combination of board and management competencies."

Despite Lockhart's contention, there does appear to be increasing evidence of relationships, if not actual causation, between board and organisational performance. McDonagh (2005 and 2006), in a study involving 64 nonprofit hospitals in the USA using the BSAQ instrument (Chait et al., 1993) to measure board performance, found a

positive correlation between BSAQ scores and hospital financial performance. She also found correlations between BSAQ scores and aspects of an independent hospital performance rating programme. And Hawthorne, et al., (2005), writing of their findings relating governance decisions made by the board of Texas Health Resources in the USA, found that there was a strong correlation between key actions of the board and both financial and market share performance indicators.

The ultimate test of board effectiveness is that the organisation achieves its purpose (Colley, 2005; Oliver, 2006). In healthcare, this relates to patients. There is a dearth of published information relating governance performance to patient outcomes and experience. However, Knecht (2007) provides some evidence from the USA of board practices that improve clinical performance. Again in the USA, a study of board development in two hospitals, each using the same conceptual model, showed improvement in board performance (Kovner et al., 1997). The study did not, however, investigate whether improved board performance resulted in improved hospital performance.

In the wider nonprofit field, Green and Griesinger (1996) studied the tasks and responsibilities of nonprofit boards of directors of social service organisations and found a significant relationship between board performance and organizational effectiveness. And Brown (2005), using the BSAQ tool (Chait et al. 1993), found significant correlations between strategic and interpersonal dimensions of board performance and organisational performance. Not all researchers, however, have found significant results. Bradshaw et al. (1992), for example, in a study of Canadian nonprofit organisations found “limited” evidence of a link between board behaviours

and objective indicators of organisational performance. They did, however, find a positive correlation between board members' own perceptions of board effectiveness and a range of board process characteristics.

In the corporate world, there is a significant, and increasing, amount of research into corporate governance and its relationship to firm performance. In the USA, Agarwal et al. (2006), in a study of more than 5,200 firms in the USA, looked at 64 governance attributes and found a positive and statistically significant relationship between governance and firm value. In Hong Kong, Cheung et al. (2005) found a statistically significant correlation between the market value of 168 listed companies and a self-developed corporate governance index. And in the UK, Hermes Pension Management has undertaken an extensive review of corporate governance and performance looking for evidence of a link between the two (Hermes, 2005). They conclude that much of the 'governance-ranking' research that is conducted in the private sector provides support for the proposition that good corporate governance improves company performance. Like others, however, (e.g. Bradshaw et al., 1992; Lockhart, 2005) they contend that "It is notoriously difficult to prove causation."

iii) Measuring board performance in nonprofit organisations

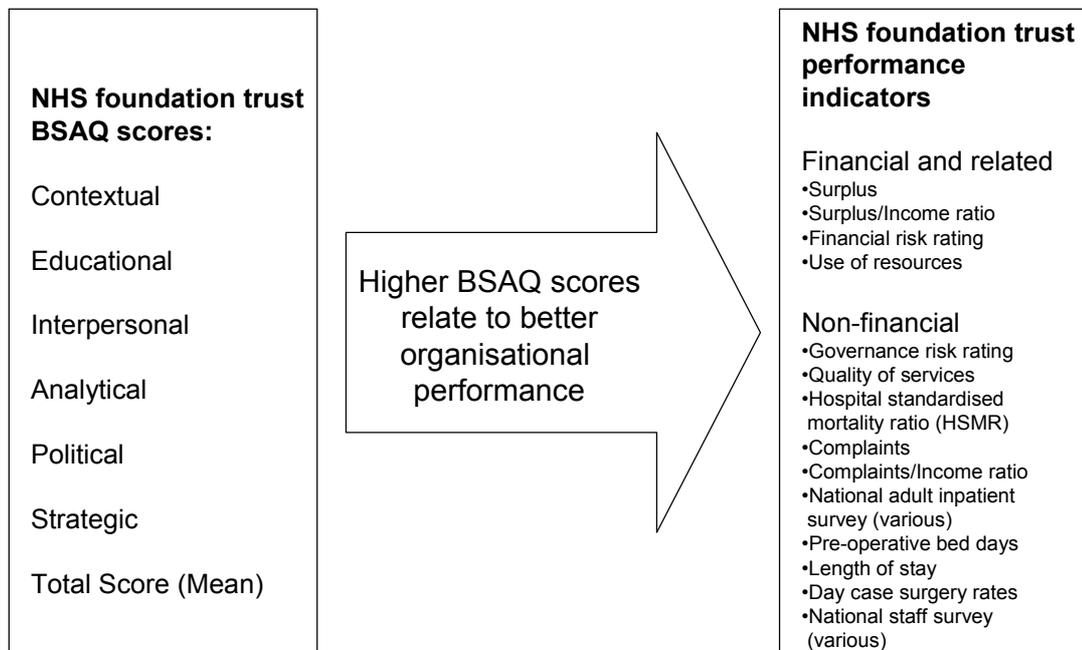
A key requirement for undertaking this study was a robust, empirically validated instrument for measuring board performance on a self-assessment basis. Given the findings of literature review above, the instrument had to be principally behaviour rather

than structure-based. Within the timeframe for undertaking this research, developing such an instrument was not considered realistically feasible.

From review of the literature, it became clear that the only extensively validated existing tool for measuring board performance in nonprofit organisations appeared to be the BSAQ instrument. Extensive research conducted on nonprofit governing boards and their effectiveness (Holland, Chait, & Taylor, 1989; Holland & Jackson, 1998; Jackson & Holland, 1998; Chait et al., 1993; Holland, 2002) resulted in development of the instrument and the identification of six dimensions, competencies, or factors of effective board performance. These factors - contextual, educational, interpersonal, analytical, political, and strategic – were the focus for this study and are described in more detail in Appendix 1.

Figure 2.1 presents a conceptual framework for exploring these factors in relation to organisational performance in NHS foundation trusts. The remainder of this dissertation presents the results of research with NHS foundation trust boards using the BSAQ instrument to answer the research questions outlined in Chapter 1.

Figure 2.1 – Conceptual framework for exploring the factors that measure the performance of the board of directors of NHS foundation trusts and the association between board and organisational performance. *Adapted from McDonagh (2005, p. 30).*



CHAPTER 3 - RESEARCH METHODOLOGY

This was a quantitative study with a cross sectional design, involving web-based administration of an extensive survey instrument, which included the Board Self-Assessment Questionnaire (BSAQ - Appendix 2), to board members of NHS foundation trusts. The web survey tool employed was SurveyMonkey¹, which was selected principally because it offers the option, for a modest additional monthly fee, to securely encrypt the data being entered by the survey respondent locally, and collect the data using a secure server. A concern about data security was regarded as a possible obstacle to NHS foundation trusts participating in the study. No other concerns of an ethical nature related to the research were established.

There was an informal qualitative aspect to the study. During May and June 2007 the researcher and his wife took time off in Harrogate to have a baby at Harrogate NHS Foundation Trust. This afforded the opportunity to conduct face-to-face, semi-structured, confidential interviews with most of the 14 trust board members plus the head of corporate affairs. The few board members unable to be interviewed in June were subsequently interviewed by telephone in August. The aim was not to include the findings in this dissertation. Rather, it was to inform the work associated with the dissertation. Many useful insights into practical foundation trust board and organisational performance issues were provided by the interviewees.

This was a part-time research project, reflecting the fact that the researcher was undertaking his studies on a part-time basis. The research was undertaken on a planned

¹ www.surveymonkey.com

basis between October 2006 and September 2007, inclusive. The initial six-stage outline research plan was to:

1. Undertake an initial literature study from October to December 2006, inclusive.
2. During December 2006 and January 2007, and based on the literature review, identify a suitable instrument to measure board performance, on a self-assessment basis, either through use of an existing instrument, or design of a new instrument.
3. Undertake testing of the board performance measurement instrument with a small number of foundation trusts during February and March 2007.
4. Administer the board performance measurement instrument as a web-based survey tool between April and July 2007.
5. Conduct informal, confidential, semi-structured interviews with board members of Harrogate and District NHS Foundation Trust during June 2007.
6. Analyse survey results, finalise literature review and write-up dissertation during August and September 2007.

The initial research plan was largely adhered to. The Board Self-Assessment Questionnaire (BSAQ – Chait, Holland and Taylor, 1993) was identified as a suitable tool for the study. A pilot study to test contextual acceptability of the BSAQ was conducted with the chairs and chief executives from a ‘convenience sample’ of three foundation trusts. The pilot exercise resulted in minor modifications to the following 8 of the original 65 BSAQ questions – 6, 17, 25, 29, 47, 48, 50 and 54. In addition, the original BSAQ reverse scored question 64 - ‘Members of this board seldom attend social events sponsored by this organisation’ - was replaced by the following normal scored question – ‘This board meets socially as a group’. These modifications were

made to reflect the context of NHS foundation trusts and, with the exception of question 64, did not affect the original intent of the questions.

Toward the end of April 2007 the chairs and chief executives of the 62 NHS Foundation Trusts in place at 1 April 2007 were formally invited to participate in the research and were encouraged to invite their board colleagues to participate also. The web based survey was opened for responses on 24 April 2007, with a view to closing the survey on 9 July 2007. A follow-up mailshot was sent to all chairs and chief executives of the 62 foundation trusts at the end of May 2007. At the end of June 2007 most of the non-responding trusts were contacted by telephone as a further follow-up. Several said they had not seen either the original or follow-up invitations to participate and so these were re-sent by e-mail and the survey period was extended until 31 July 2007.

Organisational performance data for the responding trusts was accessed from a variety of sources (see Chapter 4), including the annual reports for the 21 foundation trusts responding to the study. To help preserve the promised anonymity of the responding trusts these reports are not referenced in this dissertation.

All statistical analysis was conducted using SPSS version 11.5. Statistical tests were carried out in accordance with the relevant test assumptions. Where appropriate, Q-Q plots were produced using SPSS to confirm normal distribution of variables. All tests of significance assumed a 2-tailed test. Given the nature of the study, and the fact that, arguably, one-tailed tests might have been acceptable in many instances, statistical significance values at the $p=.1$ level were accepted as being worthy of highlighting, although the preferred acceptance threshold was $p<.05$.

CHAPTER FOUR – RESULTS, ANALYSIS AND DISCUSSION

4.1 Introduction

The purpose of this study was to explore the factors that measure the performance of boards of directors ('the board') of NHS foundation trusts and the association between board and organisational performance. The study investigated six dimensions of effective board performance - contextual, educational, interpersonal, analytical, political and strategic - as suggested by Chait, Holland and Taylor (1993) from their extensive research involving nonprofit boards, including hospitals, in the USA. These performance dimensions are derived from a 65 item Board Self-Assessment Questionnaire (BSAQ), which was originally developed by Chait et al. (1993) and which was slightly modified, based on a short pilot study involving three NHS foundation trusts, to suit the context of the current study. The BSAQ was administered as a web-based survey questionnaire. A copy of the questionnaire can be found at Appendix 2. Appendix 3 provides a breakdown of the BSAQ questions arranged into the six dimension of effective board performance outlined above.

Three principal research questions were identified:

1. Are the six dimensions of effective board performance suggested for nonprofit boards in the USA by Chait, Holland and Taylor (1993) similar in the context of NHS foundation trust boards of directors?

2. Given the unitary nature of foundation trust boards of directors, is there a difference in perception of board performance between executive and non-executive directors?
3. Is there an association between board performance, as measured using the BSAQ instrument, and organisational performance in NHS foundation trusts, as defined by publicly available data providing objective measures of financial and non-financial performance?

The specific null hypotheses resulting from these questions are as follows:

1. There is no similarity in the dimensions of effective board performance suggested by Chait, Holland and Taylor (1993) and those that apply in the context of NHS foundation trust boards of directors.
2. There is no difference in perception of board performance between executive and non-executive directors.
3. There is no association between performance of the board of directors, as measured using the BSAQ instrument, and organisational performance, as defined by selected publicly available financial and non-financial performance data.

In addition to the principal research questions above, the following supporting questions, the results of which were considered to provide useful underpinning information for this study, were posed in the web-based survey questionnaire²:

² Note that in the questionnaire presented in Appendix 2 these questions were randomly re-arranged given the link between questions 3 and 4.

1. What governance approach has the board adopted, or is it planning to adopt, e.g. Monitor Code of Governance, Department of Health Integrated Governance framework, etc.
2. From whom do board members believe that the board derives its authority, i.e. Department of Health, Monitor, the Board of Governors or Patients and the Public?
3. To what extent do board members feel that the success of the organisation is in the hands of the board today as compared to five years ago; and to what extent do they expect success to be in the hands of the board in five years time?
4. What is the perception of board members about the influence, or impact of the board on organisational performance?

This chapter presents a profile of the NHS foundation trust sample data gathered during the study; sets out the findings in relation to the supporting questions above; and presents the findings in relation to each of the three principal research questions and their null hypotheses outlined above.

4.2 Profile of NHS foundation trust sample

A total of 79 usable responses to the web-based survey questionnaire were received from executive and non-executive board members representing 21 NHS foundation trusts (33.9% organisational response). Table 4.1 provides an overview of the sample together with details of 'sub-sets' of the sample used in analyses contained in this chapter. Table 4.2 provides an overview of the types of foundation trusts responding to the survey in relation to all types of trusts in the population of 62 trusts in place at 1 April 2007.

Table 4.1 – Sample profiles

Sample type	Sample size - N	Population size	Sample size %	Description
Foundation trust sample.	21	62 ^a	33.9	The total number of foundation trust boards from which at least one board member participated in the survey.
Individual respondent data (all board members).	79	263 ^b	30.0	The number of usable web-based survey responses from individual board members, both executive and non executive directors, across the sample of 21 foundation trusts boards.
Sub-set of individual respondent data (executive directors).	42	130	32.0	The number of executive directors responding across the sample of 21 foundation trust boards.
Sub-set of individual respondent data (non-executive directors).	37	133	28.0	The number of non-executive directors responding across the sample of 21 foundation trust boards.

^a As at 1 April 2007

^b Population taken as total number of board members in the sample of 21 foundation trusts

Table 4.2 – Breakdown of sample by type of foundation trust

Type of foundation trust	Population numbers	Sample numbers	Sample percentages
Acute - Teaching	11	2	18.2
Acute - Large	11	4	36.4
Acute - Medium	15	9	60.0
Acute - Small	6	3	50.0
Specialist	11	3	27.3
Community/Mental Health	6	0	0.0
Multiservice	2	0	0.0
Totals	62	21	-
Percentages	100.0	33.9	-

An organisational response rate of 33.9% for this type of research study is considered good. NHS organisations are notoriously difficult to gain access to for research purposes (West et al., 2002). NHS board members, in particular, are extremely difficult to access. At the time of conducting the research associated with this study at least two governance surveys involving NHS board members were being carried out by authoritative, independent organisations. The demands placed on board members' time, especially given the fact that boards are a part-time group of individuals, are significant. Follow-up telephone calls to several non-responding trusts found that many of them felt they did not have the capacity to respond to "another survey." The boards of two of the trusts contacted said they wanted to participate but felt they could not as they were, at the time, without a chair and/or chief executive. Whilst it would have been good to have a higher response rate, the sample can be considered to be an, essentially, random one and no significant study limitations were experienced.

Table 4.3 sets out, for each foundation trust in the sample, the number of board members responding with a breakdown between executive and non-executive director and specification of the number of board members responding as a percentage of the entire board³. The mean number of board members on each board comprising the sample of 21 foundation trusts at August 2007 was 12.5 (range 10-16). The mean number of board members responding to this study was 3.8. The mean board member response rate was 30% (range 6.7%-60%).

³ Information on the number of board members for each foundation trust is publicly available on the Monitor website at www.monitor-nhsft.gov.uk

Table 4.3 – Profile of respondents

Foundat- ion trust	Number of respondents	Executive Directors	Non- executive Directors	% of board members responding
1	2	2	0	15.4
2	1	0	1	8.3
3	1	0	1	8.3
4	2	2	0	18.2
5	5	1	4	45.5
6	6	2	4	40.0
7	5	2	3	31.3
8	3	0	3	27.3
9	1	1	0	8.3
12	3	1	2	27.3
11	5	4	1	50.0
10	3	2	1	27.3
13	5	4	1	41.7
15	9	4	5	60.0
14	1	0	1	6.7
16	8	5	3	57.1
19	3	2	1	23.1
17	1	1	0	7.7
18	2	1	1	18.2
20	7	4	3	50.0
21	6	4	2	54.5
Total	79	42	37	-
Mean	3.8	2.0	1.8	30.0

4.3 Survey questionnaire results

The Board Self-Assessment Questionnaire (BSAQ) was used to measure board performance on a web-based self-assessment basis. The BSAQ contains 65 questions, or items, which can be ‘consolidated’ into the six board performance dimensions being investigated in the current study. The table at Appendix 4 displays all 65 BSAQ items together with the mean score and standard deviation for each item based on the data obtained from the 79 survey respondents. The items in the table at Appendix 4 are sorted by the highest mean. The respondents rated each item on a 4-point Likert-type metric (3 = ‘strongly agree’, 2 = ‘agree’, 1 = ‘disagree’ and 0 = ‘strongly disagree’). All

items shown in italics were reverse 'scored' (i.e. 0 = 'strongly agree', 1 = 'agree', 2 = 'disagree' and 3 = 'strongly disagree'). The implication of reverse scoring is that the question should be interpreted in the opposite way to which it was written. For example, question item 15 – 'Differences of opinion in board decisions are more often settled by vote than by more discussion' - should be interpreted as 'Differences of opinion in board decisions are more often settled by more discussion than by vote'.

The highest rating in the table at Appendix 4 was for interpersonal dimension item 15 – 'Differences of opinion in board decisions are more often settled by vote than by more discussion'. As a reverse-scoring item, this should be interpreted as 'Differences of opinion in board decisions are more often settled by more discussion than by vote.' Thus, discussion rather than voting is the preferred means of making board decisions in NHS foundation trusts, which should be considered good governance practice.

The next four highest ratings were:

- 'I am able to speak my mind on key issues without fear that I will be ostracised by some members of this board' (interpersonal dimension). This indicates that board members feel they operate in a culture of openness and integrity.
- 'This board takes regular steps to keep itself informed about important trends in the local health economy, and in the wider national healthcare environment, that might affect the organisation' (analytical dimension). This indicates that boards are outward looking and actively seek information on what is happening in the wider external healthcare environment.

- ‘I have participated in board discussions about the effectiveness of our performance’ (educational dimension). This indicates that boards are actively discussing board performance matters.
- ‘One of the reasons I joined this board was that I believe strongly in the values of this organisation’ (contextual dimension). This indicates that the board members are attracted to the altruistic values associated with NHS organisations, being, as they are, nonprofit public benefit organisations that do good for patients.

At the lower end of the questionnaire ratings, board members felt that boards fare less well in terms of:

- cultivating future boards leaders (interpersonal dimension);
- providing a mentor for new members joining the board (educational dimension);
- acknowledging responsibility for ill-advised decisions (educational dimension);
- meeting socially as a group (interpersonal dimension); and
- former board members participating in special events designed to convey to new members the organisation’s history and values (contextual dimension).

Table 4.4 provides, for each foundation trust represented in the study⁴, the aggregated BSAQ scores together with the percentage of board members responding to the survey questionnaire. The data is presented based on the BSAQ Total Score, with trusts sorted by highest score. A descriptive rating, relating to the BSAQ Total Score, is also presented. This is based on the author’s own suggested rating scale presented in Table 4.5. Descriptive rating scales such as this can be useful in summarising performance.

⁴ To preserve anonymity, foundation trust names are not presented.

The rating scale here is proposed in response to this study and has not been subjected to any systematic evaluation.

The data shows a significant spread in board performance across the 21 foundation trusts, with minimum and maximum BSAQ Total Scores ranging from 0.53 to 0.85 on a scale from 0.0 to 1.0. This equates to descriptive ratings from 'Fair' to 'Excellent' and the highest BSAQ Total Score is over 60% higher than the lowest score. The mean BSAQ Total Score is 0.69. The mean scores for the six dimensions of board performance range from 0.66 to 0.74. and standard deviations across the BSAQ scores range from 0.08 to 0.11, which equates to an approximate variation of around 12-16% in scores based on the mean BSAQ Total Score. There is no obvious relationship between the percentage of board members responding to the study and BSAQ scores. It is, however, perhaps worth noting that those trusts attaining 'Excellent' ratings are characterised by a low percentage of board members responding.

Table 4.4 – BSAQ scores for foundation trusts sorted by BSAQ Total Score

Foundat- ion trust	% of board memb- ers respo- nding	Board performance dimensions						BSAQ Total Score	Rating ^a
		Contextual	Educational	Interpersonal	Analytical	Political	Strategic		
1	15.4	0.89	0.81	0.85	0.80	0.85	0.89	0.85	Excellent
2	8.3	0.72	0.86	0.79	0.87	0.71	0.92	0.81	Excellent
3	8.3	0.74	0.92	0.86	0.78	0.71	0.76	0.80	Excellent
4	18.2	0.79	0.75	0.79	0.77	0.83	0.83	0.79	Very good
5	45.5	0.73	0.74	0.73	0.83	0.77	0.82	0.77	Very good
6	40.0	0.71	0.69	0.69	0.75	0.74	0.76	0.72	Very good
7	31.3	0.78	0.64	0.61	0.74	0.72	0.82	0.72	Very good
8	27.3	0.72	0.58	0.67	0.78	0.76	0.77	0.71	Very good
9	8.3	0.78	0.67	0.61	0.70	0.71	0.78	0.71	Very good
10	27.3	0.66	0.71	0.72	0.73	0.67	0.72	0.70	Very good
11	50.0	0.71	0.67	0.65	0.71	0.71	0.73	0.70	Very good
12	27.3	0.72	0.63	0.67	0.73	0.67	0.75	0.69	Good
13	41.7	0.63	0.67	0.68	0.66	0.72	0.73	0.68	Good
14	60.0	0.64	0.66	0.66	0.66	0.69	0.66	0.66	Good
15	6.7	0.61	0.56	0.64	0.70	0.67	0.78	0.66	Good
16	57.1	0.65	0.57	0.62	0.71	0.58	0.76	0.65	Good
17	23.1	0.61	0.59	0.60	0.61	0.56	0.65	0.60	Good
18	7.7	0.47	0.61	0.52	0.63	0.71	0.64	0.60	Good
19	18.2	0.54	0.53	0.55	0.68	0.66	0.60	0.59	Fair
20	50.0	0.61	0.55	0.55	0.56	0.60	0.57	0.57	Fair
21	54.5	0.54	0.48	0.49	0.56	0.58	0.52	0.53	Fair
Mean	30.0	0.68	0.66	0.66	0.71	0.70	0.74	0.69	-
Min	6.7	0.47	0.48	0.49	0.56	0.56	0.52	0.53	-
Max	60.0	0.89	0.92	0.86	0.87	0.85	0.92	0.85	-
SD	18.1	0.1	0.11	0.1	0.08	0.08	0.1	0.08	-

^a See Table 4.5

Table 4.5 – Suggested rating scale for BSAQ scores

BSAQ Score	Rating
<0.3	Poor
0.3-0.49	Weak
0.5-0.59	Fair
0.6-0.69	Good
0.7-0.79	Very good
0.8-0.89	Excellent
0.9-1.0	Exceptional

4.4 Responses to supporting questions

In this section the findings from the responses to the supporting questions outlined in section 4.1 are presented.

i) Findings for SQ1 - What governance approach has the board adopted, or is it planning to adopt?

Table 4.6 shows that all 21 foundation trusts in the sample either have adopted, or are adopting the Monitor Code of Governance for NHS foundation trusts (Monitor, 2006). The Monitor Code is based on the UK Combined Code of Corporate Governance (Financial Reporting Council, 2006). Principle A.1 of the Monitor Code requires that “Every NHS foundation trust should be headed by an effective board of directors, since the board is collectively responsible for the exercise of the powers and the performance of the NHS foundation trust.” This finding highlights the need for boards to have the tools and skills to be able to properly assess and judge their performance in relation to effectiveness and the association between board and organisational performance.

In addition to the Monitor Code, some trusts are also looking to adopt other governance approaches. Principal among these is the Department of Health’s ‘Integrated Governance’ guidance (Department of Health, 2006). Other approaches to governance being implemented by foundation trusts include the Chartered Institute of Management Accountant’s Enterprise Governance framework that attempts to link corporate governance with business performance (CIMA, 2004), mutual governance (Hunt, 2006) and Policy Governance (Emslie et al., 2006).

Table 4.6 – Breakdown of governance approach being adopted by foundation trusts

Governance approach	Total	%
Department of Health Integrated Governance framework	16	76.2
Enterprise Governance (Chartered Institute of Management Accountants)	2	9.5
Monitor Code of Governance	21	100.0
Mutual Governance	2	9.5
Policy Governance [®] (the Carver model)	1	4.8
UK Combined Code on Corporate Governance	15	71.4
Other	7	33.3

ii) Findings for SQ2 - From whom do board members believe that the board derives its authority?

Fundamental to governance is the source from which a board derives its authority or legitimacy to act (Carver, 2006; Umbdenstock, 2006). This study sought to test board members on their understanding of the source of the board’s authority through the question “From whom would you say that your board derives its authority?” In the web questionnaire board members could choose one of four responses. These, together with the results, are presented in Table 4.7.

Table 4.7 – Breakdown of respondents’ perception of source of board authority

	Executive		Non-executive		All board members	
	N	%	N	%	N	%
Department of Health	2	4.8	3	8.1	5	6.3
Monitor – NHS foundation trust regulator	29	69.0	16	43.3	45	57.0
Board of Governors	8	19.1	13	35.1	21	26.6
Patients and Public	3	7.1	5	13.5	8	10.1
Totals	42	100.0	37	100.0	79	100.0

Table 4.7 shows that 57% of board members believe the board of directors derives its authority from Monitor, the independent regulator of NHS foundation trusts. This is an

interesting finding because, in governance terms, the board of director's authority comes from the board of governors⁵ as the representative body of the foundation trust's membership. Monitor does, however, provide 'terms of authorisation' for each foundation trust to exist. Consequently the responses to this question might suggest that more work needs to be done to make board members clear about foundation trust governance and, in particular, the difference between board authority and regulatory authorisation. The responses might also suggest that there was some confusion over the word 'authority', given its regulatory use in terms of 'authorisation'. The term 'legitimacy' may, with hindsight, have been a better term to use.

iii) Findings for SQ3 - What is the perception of board members about the influence, or impact of the board on organisational performance?

Table 4.8 shows the breakdown of respondents' subjective perception of board influence, or impact on overall organisational performance. Almost 80% of respondents believe that board impact is either 'large' or 'very large.' A nonparametric bivariate correlation was calculated between the ordinal responses to board members' perception of board impact on organisational performance with the calculations of BSAQ Total Score for each board member. A moderately strong, highly significant correlation was established (Spearman's correlation: $r=.45$, $p=.000$, $N=79$), indicating that individual board members' overall subjective view of board impact on performance is related to the BSAQ board performance scores determined more objectively from board members' responses to the 65 item BSAQ instrument.

⁵ Some foundation trusts use other terms to describe the concept of a board of governors, for example a 'council of governors' or 'member's council'.

Table 4.8 – Breakdown of respondents’ perception of board impact on organisational performance

Response	Executive		Non-executive		All board members	
	N	%	N	%	N	%
Very small	0	0	0	0	0	0
Small	1	2.4	0	0	1	1.3
Moderate	9	21.4	6	16.2	15	19
Large	25	59.5	21	56.8	46	58.2
Very large	7	16.7	10	27.0	17	21.5
Total	42	100.0	37	100.0	79	100.0

iv) Findings for SQ4 - To what extent do board members feel that the success of the organisation is in the hands of the board today as compared to five years ago; and to what extent do they expect success to be in the hands of the board in five years time?

Table 4.9 presents summary statistics for this supporting question. In essence, board members feel that over the 10 year period in question (i.e. minus 5 years to plus five years) the success of the organisation is increasingly in the hands of the board, with the mean score rising from 2.9 to over 4.5. This equates to an almost 56% increase in mean score over the 10 year period. The standard deviations reduce over the period in question. This suggests greater certainty among board members about future rather than past board-related organisational success.

Table 4.9 – Breakdown of respondents’ perception of board impact on organisational success over 10 year timeframe

	Executive		Non-executive		All board members	
	Mean ^a	SD	Mean ^a	SD	Mean ^a	SD
5 years ago	3.1	0.93	2.7	0.65	2.9	0.83
Today	4.1	0.63	4.1	0.66	4.1	0.64
In five years time	4.5	0.59	4.5	0.59	4.5	0.60

^a Based on ordinal scale, 1-5

4.5 Research question 1 – Are the six dimensions of effective board performance suggested for nonprofit boards in the USA by Chait, Holland and Taylor (1993) similar in the context of NHS foundation trust boards of directors?

The six dimensions of effective board performance suggested for nonprofit boards in the USA by Chait, Holland and Taylor (1993) derive from the 65 item Board Self-Assessment Questionnaire (BSAQ – see Appendix 2). The dimensions of effective board performance, or board competency factors, are contextual, educational, interpersonal, analytical, political and strategic. The BSAQ instrument is an extensively researched and validated tool devised from research into the characteristics of effective nonprofit organisations in the USA, including hospitals. The tool was successfully used in McDonagh's (2005) doctoral study looking at the relationship between board and organisational performance in 64 nonprofit hospital organisations in the USA.

In pilot testing the questionnaire with several board members in three trusts only minor changes were identified as necessary for the instrument to be understood in an NHS foundation trust context. Consequently, the potential for meaningful use of the instrument was considered to be high. However, confirmation was needed on whether there was a similarity in the dimension, or factor structure used to measure board performance between the US nonprofit and NHS foundation trust contexts. With satisfactory pilot testing and successful use of a statistical technique called 'factor analysis' we can have confidence in the BSAQ as a valid, robust and reliable tool for board self assessment and for board development and improvement activity.

To test the similarity in board performance factor structures a series of factor analysis studies were conducted on the foundation trust survey data using SPSS. Factor analysis,

in essence, identifies what variables group or go together. According to Stapleton (1997), factor analysis is a statistical technique that indicates which, and to what degree, variables relate to an underlying and undefined factor. The substantive meaning given to a factor is typically based on the researcher's careful examination of what the high loading variables measure. Put another way, the researcher must ask what these variables have in common. Gorsuch (1983 – quoted in Stapleton, 1997) puts this in context by telling us that "all scientists are united in a common goal: they seek to summarize data so that the empirical relationships can be grasped by the human mind." The purpose of factor analysis, he said, "is to summarize the interrelationships among the variables in a concise but accurate manner as an aid in conceptualization." Thus, board performance is conceptualised in the 65 item BSAQ instrument in terms of the six dimensions, or factors - context, educational, interpersonal, analytical, political and strategic.

Initially, factor analysis studies were carried out on each of the six dimensions of board performance individually (i.e. context, educational, interpersonal, analytical, political and strategic) using the 'raw' data from the question items contained within each scale. Additional studies were carried out on the data representing the 65 questionnaire items as a whole, and also on the aggregate data representing the six board performance dimensions. All analyses are set out below.

i) Factor analysis involving individual board performance dimensions

The fundamental question that needs to be answered is “is each board performance dimension characterised by one dominant factor?” If it is, then we can be assured that each scale is measuring a single underlying construct. In the case of the BSAQ instrument, these constructs are the six board performance dimensions.

Table 4.10 sets out the number of items (N), Cronbach’s Alpha reliability factor (Alpha), Kaiser-Meyer-Olkin measure of sampling adequacy (KMO) and % of the total variance explained by the first three factors extracted through ‘principal component analysis’ using SPSS. Cronbach’s Alpha (or Alpha) is “a coefficient that describes how well a group of items focuses a single idea or construct” (Iowa State University, 2007). Alpha assumes that there is only one construct being measured, although it should be noted that Alpha says nothing about how well a construct is covered. This means it is possible to have a high Alpha (i.e. .70 or higher) indicating that the scale items, or questions are focusing on one construct, but only part of the breadth of the construct may be covered. Hence we need to perform factor analysis studies to provide additional insights into the constructs. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy tests whether the partial correlations among variables are small. The KMO value should be greater than 0.5 for a satisfactory factor analysis to proceed (Newcastle University, 2007).

Reassuringly, for the foundation trust data collected in this study each board performance dimension, or scale, demonstrated high Alpha and KMO statistics. Given the KMO statistics (i.e. significantly greater than 0.5) it was concluded that factor

analysis was appropriate with this data set. From Table 4.10, the percentage of variance explained by the first factor in each of the six performance dimensions, or competency scales ranged from 43.3% (strategic) to 30.1% (contextual). The second and subsequent factors account for increasingly less of the total variance. This indicates presence of a dominant factor, i.e. dominant underlying construct, in each scale. Jackson and Holland's (1998) factors ranged from 41% (strategic dimension) to a "disappointing" 24% (interpersonal dimension). Their goal was to have a dominant first factor accounting for at least 40% of the total variance in each of the six scales. They did not achieve this goal. Consequently, they carried out a 'Cattel's scree test' on each scale to assure themselves, graphically, through a 'scree plot', the presence, or otherwise, of one dominant factor.

Table 4.10 – Results of factor analysis involving individual board performance dimensions

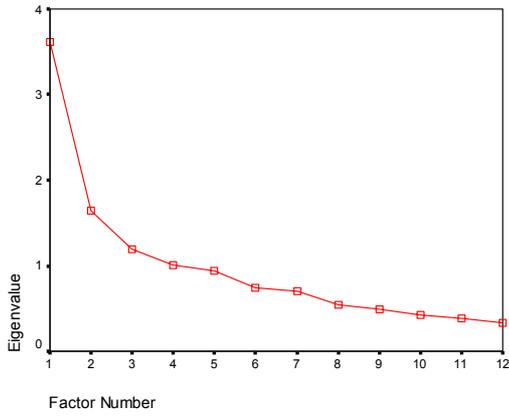
Dimension	N	Alpha	KMO	% of Total Variance		
				1 Factor	2 Factors	3 Factors
1. Contextual	12	.76	.76	30.1	43.8	53.7
2. Educational	12	.83	.77	36.6	49.2	60.8
3. Interpersonal	11	.77	.76	32.0	45.6	55.6
4. Analytical	10	.76	.77	33.1	45.2	56.8
5. Political	8	.75	.70	37.3	51.0	63.2
6. Strategic	12	.87	.82	43.3	53.2	62.4

The scree plot approach involves plotting the eigenvalues for each factor. Factors that explain more of the total item variance exhibit larger eigenvalues. Given that factors with larger eigenvalues are always extracted first, the scree plot presents a slope from left to right. To confirm a single factor solution for any scale, the first factor must be plotted significantly higher than the subsequent factors. The subsequent factors should level off and form a reasonably horizontal slope. Figure 4.1 presents scree plots for

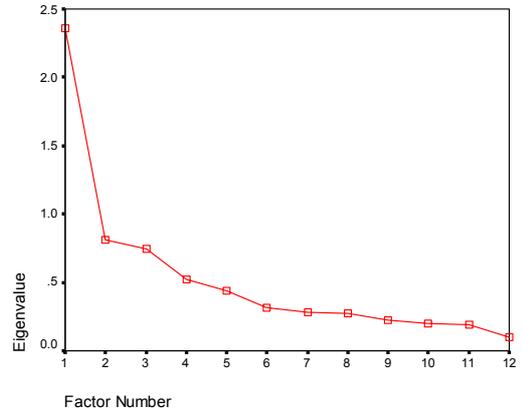
individual board performance dimensions for the foundation trust data gathered in this study. Figures 4.1(e) and (f) are almost 'ideal' scree plots showing a scale with a definite single factor solution. The other plots show, to differing degrees, the presence of other factors but, nevertheless, each plot does show a definite dominant first factor, indicating the presence of a single factor solution. Jackson and Holland's (1998) analysis exhibited slightly weaker scales than those found in this study, but they nevertheless concluded that each of their six board performance dimensions, or scales, measured a single theoretical construct.

For the purposes of this study, we can say that the six board performance dimensions can be taken as a valid attempt to consolidate the 65 item BSAQ instrument into significant and meaningful underlying constructs reflecting key dimensions of board performance. Given the single factor emphasis, it can be concluded that there is a similarity between the board performance factor structure found in the USA and the structure for the current study involving NHS foundation trusts. The null hypothesis can therefore be rejected. However, for more routine use of the BSAQ tool by boards of NHS, and other healthcare organisations, additional research could usefully be conducted to identify additional underlying constructs that might be contained within the data. Such an exercise is outwith the scope of the current study.

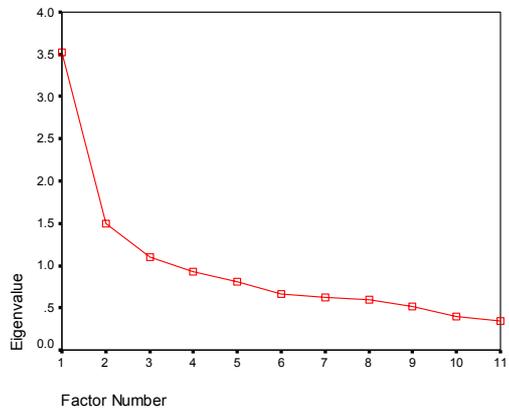
Figure 4.1 – Scree plots for individual board performance dimensions



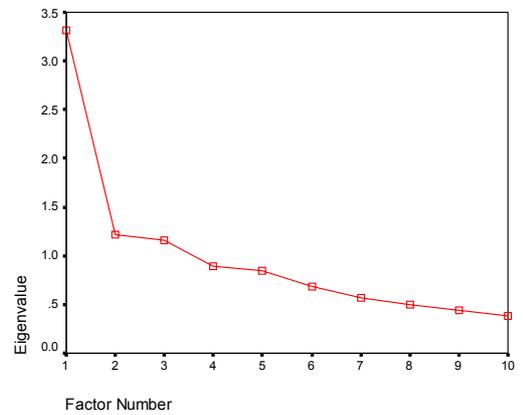
(a) Contextual dimension (N=12)



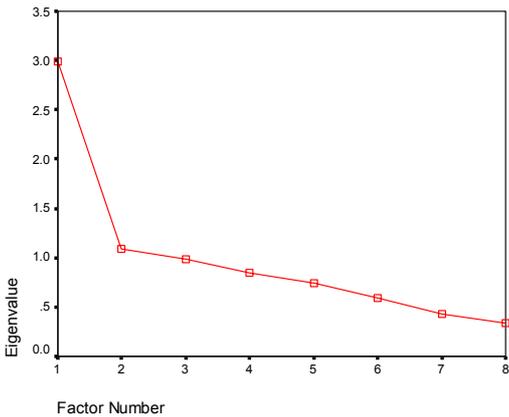
(b) Educational dimension (N=12)



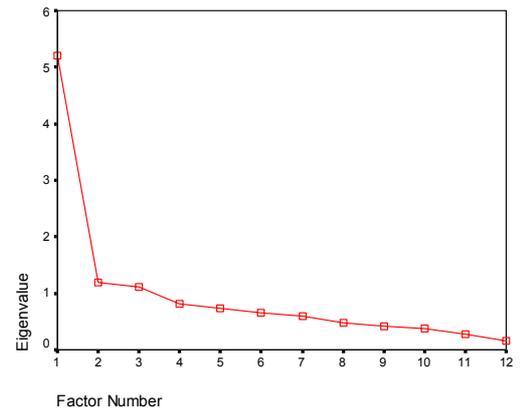
(c) Interpersonal dimension (N=11)



(d) Analytical dimension (N=10)



(e) Political dimension (N=8)



(f) Strategic dimension (N=12)

ii) Is there a single factor solution to the BSAQ data for NHS foundation trusts?

In her doctoral work exploring application of the BSAQ instrument in measuring board performance in US hospitals, McDonagh (2005) found that a strong single factor solution applied to her data. She therefore limited her use of the six board performance dimensions and, instead, focused her analysis on relating the overall BSAQ scores to measures of hospital performance. Given her findings, it was decided to carry out additional factor analysis studies on the foundation trust data to test whether a single factor solution applies. Two further factor analysis tests were conducted: a) on the data for all 65 question items comprising the BSAQ instrument; and b) on the consolidated results of calculations of board performance against each of the six board performance dimensions.

a) 65 question items

Cronbach's Alpha reliability coefficient for the 65 items across all 79 cases was 0.95. Such a high Alpha value strongly suggests that the 65 items are measuring a single construct. The KMO measure of sampling adequacy was 0.59, indicating that a factor analysis was appropriate. The results of the factor analysis across 65 items and 79 cases is presented in Table 4.11, which shows the results of a 'principal components analysis' extracting eigenvalues greater than 1.0 (known as 'the Kaiser rule'). The presence of a single dominant factor is clearly seen, as is the presence of smaller, but nevertheless significant additional factors with eigenvalues above 1.0. Factor 1 accounts for a very significant (in relation to a 65 item instrument) 26.44% of the variance, with subsequent factors accounting for less and less variance. Cumulatively, the 19 extracted factors under the Kaiser rule account for 76.6% of the variance.

The fact that under the Kaiser rule 19 factors are extracted from the 65 item BSAQ instrument has some correlation with the findings above in relation to factor analysis involving individual board performance dimensions. Careful examination of Figure 4.1, and using some judgement as to the cut off point for isolating factors on the scree plots,

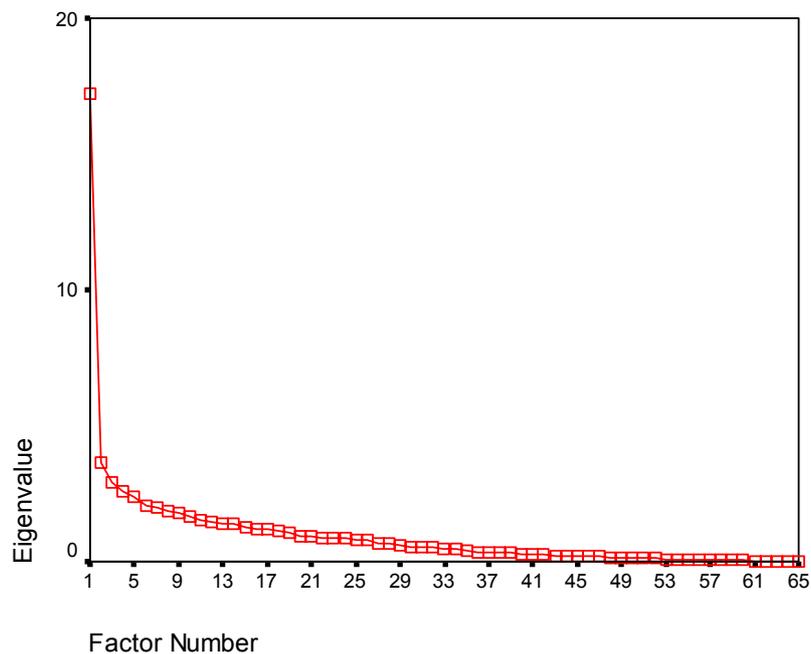
Table 4.11 – Principal components analysis for the 65 BSAQ items

Factor	Eigenvalue	% of Variance	Cumulative %
1	17.186	26.440	26.440
2	3.672	5.649	32.088
3	2.934	4.514	36.602
4	2.568	3.951	40.553
5	2.408	3.705	44.258
6	2.055	3.161	47.419
7	1.973	3.036	50.455
8	1.846	2.840	53.295
9	1.798	2.766	56.061
10	1.664	2.559	58.620
11	1.542	2.372	60.992
12	1.474	2.268	63.260
13	1.399	2.152	65.412
14	1.393	2.143	67.555
15	1.261	1.940	69.495
16	1.218	1.874	71.369
17	1.199	1.845	73.214
18	1.108	1.705	74.919
19	1.089	1.675	76.595

a total of between 10 and 18 factors can be visualised. In other words, whilst each of the six dimensions of board performance exhibit a dominant factor, the 65 item BSAQ instrument, in the context of the NHS foundation trust board data in this study, does lend itself to a larger number of factors - somewhere between the 6 factors suggested by Chait et al. (1993), or that might be inferred from the scree plots in Figure 4.1, and the 19 factors extracted through principal components analysis on responses to the 65 item BSAQ instrument and set out in Table 4.13. However, as has just been established, the

BSAQ instrument also lends itself, again in the context of the foundation trust data in this study, to an overall or ‘consolidated’ single factor solution. This is reinforced by Figure 4.2, which shows a scree plot based on foundation trust data for the entire 65 item BSAQ instrument.

Figure 4.2 – Scree plot for 65 item BSAQ instrument



b) Factor analysis involving the six board performance dimensions

Taking the scores for each of the six board performance dimensions across all 79 respondent cases, the Alpha value is calculated as 0.93 – an indication of very high reliability in that the dimensions are measuring a single construct. The KMO measure of sampling adequacy was also high at 0.9, thus carrying out a factor analysis was highly appropriate. Table 4.12 presents a correlation matrix for the six board performance dimensions. The high correlations between the dimensions provide further evidence of

a potential single factor solution. A principal components analysis using SPSS confirms the presence of a single factor solution as both the results in Table 4.13 and the scree plot in Figure 4.3 suggest.

Table 4.12 - Correlation matrix for the six dimensions of board performance

		C1*	C2*	C3*	C4*	C5*	C6*
Correlation ^a	C1*	1.000	.673	.710	.724	.641	.710
	C2*	.673	1.000	.766	.655	.579	.681
	C3*	.710	.766	1.000	.749	.622	.743
	C4*	.724	.655	.749	1.000	.699	.817
	C5*	.641	.579	.622	.699	1.000	.617
	C6*	.710	.681	.743	.817	.617	1.000

^a All correlations statistically significant to $p < .001$

* C1=contextual, C2=educational, C3=interpersonal, C4=analytical, C5=political, C6=strategic

Table 4.13 – Principal components analysis for the six dimensions of board performance

Factor	Eigenvalue	% of Variance	Cumulative %
1	4.469	74.477	74.477
2	.467	7.782	82.259
3	.370	6.165	88.424
4	.309	5.155	93.579
5	.219	3.642	97.221
6	.167	2.779	100.000

Applying the Kaiser rule, there is only one factor with an eigenvalue greater than 1.0.

Performing a factor analysis using principal components extraction based on the Kaiser rule in SPSS results in the factor loadings set out in Table 4.14. All of the six board performance dimensions load heavily onto the single factor solution. In factor analysis studies, naming the factors can be subjective and in some cases can be a matter of dispute. In this instance, it is sufficient to simply name the factor ‘BSAQ Total Score’

since the factor essentially consolidates the six board performance dimensions, or factors, identified by Chait et al. (1993) into an overall, higher level construct.

Figure 4.3 – Scree plot for the six board performance dimensions

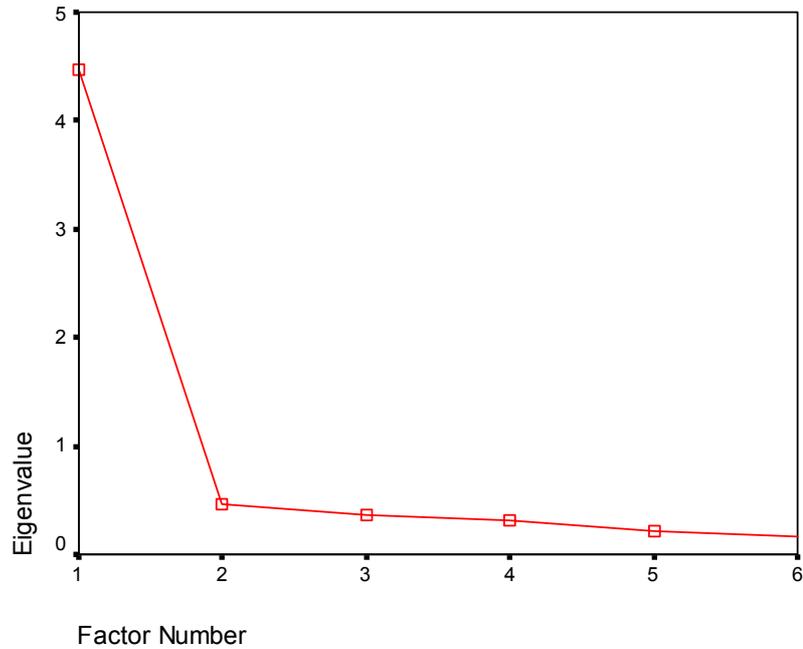


Table 4.14 – Factor loadings for the six dimensions of board performance

	Factor
	1
Contextual	.861
Educational	.840
Interpersonal	.889
Analytical	.900
Political	.798
Strategic	.885

Thus, similar to McDonagh (2005) in her study of US hospitals, we find that a single factor solution applies to the factors that measure the performance of hospital governing

boards. This finding is helpful in any attempt to consolidate and correlate board performance with organisational performance data. Unlike McDonagh (2005), however, we find that the original six board performance dimensions identified by Chait et al. (1993) do appear to have utility as independent variables in their own right in any study that seeks to establish a relationship between board and organisational performance.

4.6 Research question 2 - Given the unitary nature of foundation trust boards of directors, is there a difference in perception of board performance between executive and non-executive directors?

Given that executive directors are full-time senior management staff having dual governance and management roles and non-executive directors are part-time ‘outsiders’, sometimes with little direct experience or knowledge of NHS governance and management, there has, historically, sometimes been ‘tensions’ between the two (Deffenbaugh, 1996; NHS Confederation, 2005). These tensions, where they exist, may be rooted in fundamental differences in perception of matters related to board performance.

Tables 4.15 and 4.16 show, respectively, the ‘top ten’ and ‘bottom ten’ BSAQ question items based on rank ordering in relation to the mean scores for each item (full rank ordered listings of responses for executive and non-executive directors can be found in Appendices 3 and 4, respectively) . Inspection of tables 4.15 and 4.16 shows there to be some differences in rating the various items between executive and non-executive directors. However, in relation to both tables, i.e. ‘top ten’ and ‘bottom ten’, seven items

are common in both executive and non-executives' responses, suggesting that, perhaps, the differences may not be statistically significant.

Given this finding, a 'comparison of means' was carried out on the individual BSAQ board performance dimension scores and also the BSAQ Total Score for executive and non-executive respondents using independent samples t-tests. Table 4.17 provides a comparison of executive and non-executive board members' responses to the Board Self-Assessment Questionnaire (BSAQ). Overall, no statistically significant difference was found between the two groups of respondents (in relation to BSAQ Total Score, $t=-.71$, $df=77$, $p=.48$). As a cross check, a non-parametric independent samples Mann-Whitney U test (MWU) was carried out in relation to respondents' perception of the extent to which they felt the board influences or impacts organisational performance (see Table 4.8). Again, the result was not significant (MWU=663.5, $p=.21$). Thus, based on both tests, it can be concluded that there is no difference in perception of board performance between executive and non-executive directors and the null hypothesis is accepted.

There are, however, some statistically significant differences to be found between executive and non-executive directors at the level of their responses to individual BSAQ items. Table 4.18 identifies eight BSAQ items that exhibit a statistically significant difference – three at the $p=.05$ level and five at the $p=.1$ level – all with non-executive directors exhibiting greater agreement than executive directors (i.e. non-executive director means ranks are higher than those for executive directors). Four out of the eight items (item numbers 4, 11, 23 and 47) are from the analytical board performance dimension, which relates to boards recognising complexities and subtleties in the issues

it faces and drawing upon multiple perspectives to dissect complex problems and to synthesise appropriate responses. In relation to item 4, for example, there is a highly significant difference (MWU=545, $p=.013$) in agreement between executives and non-executive in relation to their perception of having been in board meetings where the subtleties of the issues being dealt with have escaped the awareness of a number of board members. Non-executives are more firmly of the opinion that this is the case. And in relation to BSAQ item 47, non-executives generally perceive that recommendation from the executive directors are usually accepted with little questioning at board meetings, but this appears not to be the perception of the executives (MWU=629, $p=.08$). The issue of non-executives questioning the executive directors is a known potential source of tension within NHS boards (NHS Confederation, 2005, p8).

From the foregoing it can be concluded that whilst there may be some differences between executive and non-executive directors in relation to a small number of individual BSAQ items, overall there is no statistically significant difference. This suggests that board members function in an integrated, cohesive manner, based on the principles of teamworking. In 1974, the well known management writer Peter Drucker (quoted in Carver, 2006, p16) said “There is one thing all boards have in common regardless of their legal position . *They do not function*. The decline of the board is a universal phenomenon of this century.” The collaborative functioning alluded to by this study suggests that Peter Drucker’s comments do not apply in the context of NHS foundation trusts!

Table 4.15 – Comparison of ‘Top 10’ BSAQ question items for executive and non-executive directors

Executive directors					Non-executive directors				
Rank	Question Item	M	SD	Question Item	M	SD			
1	15 <i>Differences of opinion in board decisions are more often settled by vote than by more discussion.</i>	2.76	0.43	15 <i>Differences of opinion in board decisions are more often settled by vote than by more discussion.</i>	2.62	0.55			
2	26 I have participated in board discussions about the effectiveness of our performance.	2.52	0.74	52 I am able to speak my mind on key issues without fear that I will be ostracised by some members of this board.	2.59	0.69			
3	1 This board takes regular steps to keep itself informed about important trends in the local health economy, and in the wider national healthcare environment, that might affect the organisation.	2.48	0.55	1 This board takes regular steps to keep itself informed about important trends in the local health economy, and in the wider national healthcare environment, that might affect the organisation.	2.54	0.56			
4	52 I am able to speak my mind on key issues without fear that I will be ostracised by some members of this board.	2.45	0.71	40 <i>This board has on occasion evaded responsibility for some important issue facing the organisation.</i>	2.51	0.65			
5	54 <i>The executive directors rarely report to the board on the concerns of patients.</i>	2.43	0.70	16 <i>This board delays action until an issue becomes urgent or critical.</i>	2.49	0.61			
6	56 One of the reasons I joined this board was that I believe strongly in the values of this organisation.	2.40	0.66	56 One of the reasons I joined this board was that I believe strongly in the values of this organisation.	2.47	0.62			
7	5 Our board explicitly examines the “downside” or possible pitfalls of any important decisions it is about to make.	2.33	0.61	5 Our board explicitly examines the “downside” or possible pitfalls of any important decisions it is about to make.	2.41	0.50			
8	16 <i>This board delays action until an issue becomes urgent or critical.</i>	2.33	0.53	26 I have participated in board discussions about the effectiveness of our performance.	2.38	0.72			
9	22 I find it easy to identify the key issues that this board faces.	2.33	0.61	31 The leadership of this board typically goes out of its way to make sure that all members have the same information on important issues.	2.38	0.64			
10	49 Within the past year, this board has reviewed the organisation’s strategies for attaining its long-term goals.	2.33	0.72	38 <i>I have never received feedback on my performance as a member of this board.</i>	2.38	0.79			

Table 4.16 - Comparison of 'Bottom 10' BSAQ question items for executive and non-executive directors

Executive directors					Non-executive directors				
Rank	Question Item		M	SD	Question Item	M	SD		
56	60	This board provides biographical information that helps members get to know one another better.	1.74	0.73	37	I have been present in board meetings where discussions of the history and mission of the organisation were key factors in reaching a conclusion on a problem.	1.72	0.61	
57	20	This board is as attentive to how it reaches conclusions as it is to what is decided.	1.71	0.55	23	When faced with an important issue, the board often "brainstorms" and tries to generate a whole list of creative approaches or solutions to the problem.	1.70	0.78	
58	43	This board relies on the natural emergence of leaders, rather than trying explicitly to cultivate future leaders for the board.	1.55	0.71	2	I have participated in board discussions about what we should do differently as a result of a mistake the board made.	1.69	0.70	
59	24	When a new member joins this board, we make sure that someone serves as a mentor to help this person learn the ropes.	1.48	0.67	32	This board has adopted some explicit goals for itself, distinct from goals it has for the total organisation.	1.68	0.71	
60	23	When faced with an important issue, the board often "brainstorms" and tries to generate a whole list of creative approaches or solutions to the problem.	1.40	0.63	41	Before reaching a decision on important issues, this board usually requests input from persons likely to be affected by the decision.	1.68	0.67	
61	18	I can recall an occasion when the board acknowledged its responsibility for an ill-advised decision.	1.38	0.62	64	This board meets socially as a group.	1.45	0.68	
62	32	This board has adopted some explicit goals for itself, distinct from goals it has for the total organisation.	1.38	0.62	24	When a new member joins this board, we make sure that someone serves as a mentor to help this person learn the ropes.	1.42	0.80	
63	4	I have been in board meetings where it seemed that the subtleties of the issues we dealt with escaped the awareness of a number of the members.	1.33	0.72	43	This board relies on the natural emergence of leaders, rather than trying explicitly to cultivate future leaders for the board.	1.39	0.64	
64	64	This board meets socially as a group.	1.21	0.81	18	I can recall an occasion when the board acknowledged its responsibility for an ill-advised decision.	1.32	0.63	
65	59	Former members of this board have participated in special events designed to convey to new members the organisation's history and values.	1.19	0.55	59	Former members of this board have participated in special events designed to convey to new members the organisation's history and values.	1.23	0.63	

Table 4.17 - Comparison of executive and non-executive board member's responses in relation to board performance dimensions

BSAQ performance dimension	Items	All Respondents (N=79)			t	df	Executive Directors (N=42)			Non-executive Directors (N=37)		
		Alpha	Mean ^a	SD ^a			Alpha	Mean ^a	SD ^a	Alpha	Mean ^a	SD ^a
1. Contextual	12	.76	.668	.112	-0.39	75.9 ^b	.82	.664	.125	.66	.674	.097
2. Educational	12	.83	.636	.144	0.37	77	.84	.642	.152	.82	.630	.137
3. Interpersonal	11	.77	.646	.126	-1.37	75.3 ^b	.81	.629	.140	.69	.667	.105
4. Analytical	10	.76	.693	.119	-1.7*	77	.70	.672	.105	.80	.717	.130
5. Political	8	.75	.681	.118	0.022	77	.76	.682	.119	.75	.681	.119
6. Strategic	12	.87	.714	.144	-0.75	77	.84	.702	.131	.90	.727	.158
BSAQ Total Score	65	.95	.673	.110	-0.71	77	.96	.665	.111	.95	.683	.109

^aBased on BSAQ scoring approach

^bEqual variances not assumed (based on Levene's test for equality of variances)

* p<.1

Table 4.18 – Comparison of executive and non-executive director’s responses to selected individual BSAQ items

No.	BSAQ Performance Dimension	BSAQ Item	MWU	Sig. ^a	Mean Rank	
					Executive Directors (N=42)	Non-executive Directors (N=37)
4	Analytical	I have been in board meetings where it seemed that the subtleties of the issues we dealt with escaped the awareness of a number of the members.	545**	.013	34.48	46.27
11	Analytical	Many of the issues that this board deals with seem to be separate tasks, unrelated to one another.	592.5**	.034	35.61	44.99
39	Contextual	It is apparent from the comments of some of our board members that they do not understand the mission of the organisation very well.	588**	.038	35.50	45.11
20	Interpersonal	This board is as attentive to how it reaches conclusions as it is to what is decided.	633.5*	.077	36.58	43.88
23	Analytical	When faced with an important issue, the board often “brainstorms” and tries to generate a whole list of creative approaches or solutions to the problem.	621.5*	.094	36.30	44.20
32	Interpersonal	This board has adopted some explicit goals for itself, distinct from goals it has for the total organisation.	622*	.091	33.31	44.19
40	Strategic	This board has on occasion evaded responsibility for some important issue facing the organisation.	618.5*	.083	36.23	44.28
47	Analytical	Recommendations from the executive directors are usually accepted with little questioning in board meetings.	629*	.084	36.48	44.00

^a 2-tailed

* p<.1 **p<.05

4.7 Research question 3 - Is there an association between board performance, as measured using the BSAQ instrument, and organisational performance in NHS foundation trusts, as defined by publicly available data providing objective measures of financial and non-financial performance?

Research question 3 concerns the relationship between the board of directors and measures of financial and non-financial performance in NHS foundation trusts.

Specifically, the null hypothesis is that there is no association between performance of the board of directors, as measured using the BSAQ instrument, and organisational performance, as defined by selected publicly available financial and non-financial performance data.

In this section we will look at the results of correlation studies between BSAQ scores in relation to both the six dimensions of board performance and the BSAQ Total Scores and key publicly available financial and non-financial performance data.

i) Results of correlation studies between BSAQ board performance scores and key financial performance data

Table 4.19 sets out the results of bivariate correlation analyses between BSAQ board performance scores in relation to key financial and related performance indicators.

‘Surplus’ is, essentially, the ‘profit’ made by a foundation trust whereas

‘Surplus/Income Ratio’ controls for the size of the trust, in financial terms, by dividing the generated surplus (or deficit) by the trust’s total annual income figure. The two

ratios for ‘Surplus/Income’ reflect the fact that one of the foundation trusts in the sample is a recognised outlier in terms of its financial performance, and this trust can be identified at the top of Figure 4.4 as the trust with a surplus/income ratio of almost 8%. Consequently, the data for ‘Surplus/Income Ratio B’ excludes this outlying trust.

Table 4.19 - Correlation of BSAQ scores with key financial and related performance indicators

BSAQ performance dimension	Surplus (£million) ^{a,1}	Surplus/Income Ratio A (%) ^{a,1}	Surplus/Income Ratio B (%) ^{b,1}	Financial Risk Rating ^{c,2}	Use of Resources ^{a,2} 2005/06
1. Contextual	.53**	.27	.44*	.05	-.02
2. Educational	.57***	.33	.37	-.08	.04
3. Interpersonal	.61***	.43**	.50**	-.01	.11
4. Analytical	.60***	.41*	.54**	.18	.18
5. Political	.44**	.25	.44*	.44*	.42*
6. Strategic	.73****	.44*	.68***	.22	.28
BSAQ Total Score	.66***	.40*	.55**	.08	.16

^a N=21

^b N=20

^c N=18

¹ Pearson’s correlation

² Spearman’s correlation

* p<.1 **p<.05 ***p<.01 ****p<.001

The ‘Finance Risk Rating’ is determined by Monitor, Regulator of NHS Foundation Trusts, and is an ordinal rating between 1 and 5, where 5 denotes least financial risk.

‘Use of Resources’ is a rating determined by the Healthcare Commission, who independently, on behalf of Parliament, assess all NHS organisations, including NHS foundation trusts. The rating is either ‘Excellent’, ‘Good’, ‘Fair’ or ‘Weak’. The ‘Use of Resources’ indicator is principally based on independent financial evaluations carried

Figure 4.4 – BSAQ Total Score Vs Surplus/Income Ratio A, showing outlying trust

This figure contains information that could be used to identify some of the trusts participating in this study. Consequently, to preserve anonymity, it is blanked out.

out by the Audit Commission⁶, which is an independent public body responsible for ensuring that public money is spent economically, efficiently, and effectively. All financial indicators relate to the financial year 2006/2007, with the exception of the ‘Use of Resources’ indicator, which is produced by the Healthcare Commission and relates to 2005/2006. For the ‘Financial Risk Rating’ measure, data were only available for 2006/07 for 18 foundation trusts.

There is a strong and significant correlation between most of the six dimensions of board performance, and the BSAQ Total Score, and surplus. The slightly weaker correlation on the political dimension may suggest that when it comes to matters of financial performance, connecting with the local community and other stakeholders, including staff, is not a priority concern. The results also show a strong and highly

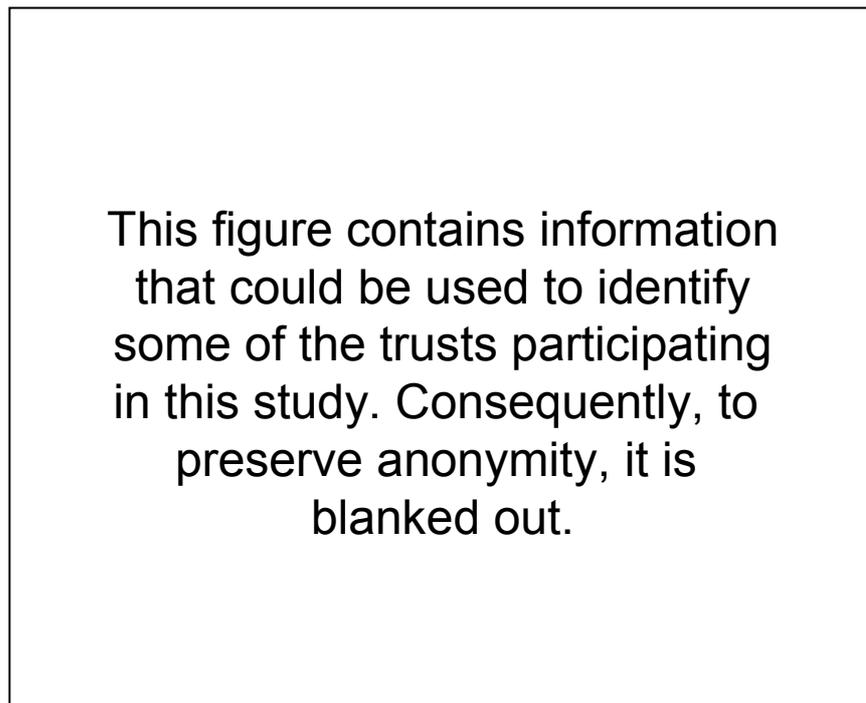
⁶ www.audit-commission.gov.uk

significant correlation between BSAQ Total Score and surplus ($r=.66$, $p=.001$).

Controlling for size of organisation (in terms of total income), and excluding data for the outlying foundation trust, there is a moderately strong, significant correlation between BSAQ Total Score and surplus/income ratio B ($r=.55$, $p=.013$). If the outlying trust is removed also from the data for surplus the revised correlation statistics between BSAQ Total Score and surplus are $r=.60$, $p=.006$, giving a slight reduction in the strength of the correlation, but the correlation remains highly significant.

The results in relation to individual board performance dimensions exhibit a range of correlation strengths and statistical significance. Of particular note is the correlation between the strategic board performance dimension and both surplus ($r=.73$, $p=.000$ – see also Figure 4.5) and surplus/income ratio B ($r=.68$, $p=.001$). These results strongly suggest that the key emphasis given by foundation trust boards to strategic issues, particularly in relation to financial matters, do result in better financial performance. With a coefficient of determination, $r^2 = .53$, we can say that 53% of the variation in financial performance can be explained by variation in board performance in relation to the strategic board performance dimension. In its September 2007 three monthly review of NHS foundation trust performance, Monitor, independent regulator of NHS foundation trusts, says that it will “continue to encourage boards of NHS foundation trusts to build strategic capabilities....” (Monitor, 2007b). The evidence presented here appears to suggest that foundation trusts are taking strategic issues seriously.

Figure 4.5 - BSAQ Strategic Score Vs Surplus



The findings in relation to Monitor's financial risk rating and the Healthcare Commission's use of resources suggest no significant association. There is, however, an association at the $p=.1$ level between the political board performance dimension and each of these ratings. This may be due to chance, or it may be because the political dimension is heavily focused on board interactions with key stakeholders, and Monitor and the Healthcare Commission are key stakeholders whom boards, for the most part, take very seriously indeed.

The results of correlation analyses between BSAQ scores, finance risk rating and use of resources rating are disappointing, but not unexpected. The dependent variables are very crude financial indicators and, indeed, may not measure what really matters in relation to financial performance. Further research is required into the utility of these indicators as robust measures of performance.

What does matter to foundation trusts is surplus generation. Without a surplus there is no money to invest in improving services for patients. The results presented here clearly indicate that increased surplus generation is strongly associated with better performing boards. That's not to say that better performing boards result in (i.e. cause) higher surpluses, but better performing boards might take the issue of surplus generation more seriously than lesser performing boards. Overall, this link between board and organisational performance is an important finding. If boards can take financial performance seriously, resulting in a positive relationship between board and financial performance, then it could be argued that if boards were to take other aspects of organisational performance seriously, similar relationships would be found.

One week before the due hand-in date for this dissertation, Monitor published the 2007/2008 first quarter's financial figures for foundations trusts for the three months until 30 June 2007, which overlaps with the data collection phase of this study. Whilst some care must be exercised in using 'unrefined' quarterly figures, nevertheless correlation analyses were carried out on available information and the results are presented in Table 4.20. Reassuringly, a moderately strong, statistically significant relationship was found between BSAQ Total Score and surplus ($r=.5$, $p=.022$ – c.f. $r=.66$, $p=.001$ for a whole year's data for 2006/2007: see Table 4.19, above). And, interestingly, a correlation at the $p=.05$ level was found between the analytical, political and strategic board performance dimensions and Monitor's financial risk rating (respectively, $r=.47$, $p=.032$; $r=.54$, $p=.012$; and $r=.44$, $p=.048$), with an overall correlation with BSAQ Total Score of $r=.39$, $p=.085$. These findings serve to reinforce the existence of a significant association between board and organisational performance in relation to financial performance matters.

Table 4.20 – Correlation of BSAQ scores with Monitor’s financial indicators for Quarter 1 (April-June) 2007/08

Item	Surplus (£million) ^{a,1}	Financial Risk Rating ^{a,2}
1. Contextual	.41*	.22
2. Educational	.48**	.26
3. Interpersonal	.44**	.25
4. Analytical	.42*	.47**
5. Political	.45**	.54**
6. Strategic	.42*	.44**
BSAQ Total Score	.50**	.39*

^aN=21

¹ Pearson’s correlation

² Spearman’s correlation

* p<.1 **p<.05

ii) Results of correlation analyses between board performance scores and key non-financial performance indicators

Table 4.21 presents the results of bivariate correlation calculations between BSAQ scores and selected key non-financial performance indicators. Because some foundation trusts are only relatively recently established, data on some performance measures were only available for 18 out of the 21 trusts in this study. ‘Governance Risk Rating’ is a simple indicator (red, amber or green) assigned by Monitor, regulator of NHS foundation trusts. ‘Quality of Services’ is a ‘composite’ indicator assigned by the Healthcare Commission and is based on trusts’ self-assessed compliance against the Department of Health’s Standards for Better Health (2004) along with compliance with a range of government targets. Both governance risk rating and quality of services are crude indicators whose utility is, perhaps, questionable.

Table 4.21 – Correlation of BSAQ scores with key non-financial performance indicators

BSAQ performance dimension	Governance Risk Rating ^{b,2}	Quality of Services ^{a,2}	HSMR 1 yr ^{b,1}	HSMR change % ^{b,1}	Complaints ^{a,1}	Complaints/Income ^{a,1}
1. Contextual	-.13	.26	-.31	-.32	.23	-.17
2. Educational	-.32	.24	-.04	-.09	.51**	.23
3. Interpersonal	-.09	.10	.05	-.09	.30	.04
4. Analytical	-.03	.21	.09	-.22	.12	-.02
5. Political	-.16	.22	.06	-.03	.17	.10
6. Strategic	-.34	.27	.07	-.08	.16	-.05
BSAQ Total Score	-.21	.31	-.02	-.16	.31	.04

^a N=21

^b N=18

¹ Pearson's correlation

² Spearman's correlation

* p<.1 **p<.05 ***p<.01 ****p<.001

'HSMR' is 'Hospital Standardised Mortality Ratio', which is considered to be an effective way to measure and compare clinical performance, safety and quality in hospitals (Dr Foster Intelligence, 2007). HSMRs compare the number of expected patient deaths in hospital with the number of actual deaths. Patient deaths are an unequivocal health outcome, are relatively easy to measure and all deaths must be reported by law. The figures for HSMR used in this study were for 2005/06. A corresponding measure, 'HSMR change %', is the percentage change in HSMR from 2004/05 to 2005/06. This measure tells whether hospitals, in this case NHS foundation trusts, are improving their mortality ratio through, for example, taking effective action to improve the safety and quality of patient care. Hypothetically, better performing boards should be associated with improvements in HSMR, but the figures presented in Table 4.21 provide no evidence of this.

There does appear to be an association between the number of complaints received by each trust and the BSAQ educational board performance dimension ($r=.51$, $p=.019$). It may be that better performing boards create a culture that encourages complaints as a learning opportunity for improving the quality of services. Complaints data tend to be regularly monitored by foundation trust boards. It is interesting to note, however, that the number of complaints received by a trust is strongly correlated with the size of the trust in terms of its financial income ($r=.88$, $p=.000$). Controlling for size of trust using the measure 'Complaints/Income' we see in Table 4.21 that there are no apparent associations with BSAQ board performance scores.

Table 4.22 presents data on bivariate correlation calculations between board performance dimensions and key national patient survey and clinical productivity indicators. The 'Patient care' indicator is calculated as the mean score for all responses to key questions contained in the 2006 national adult inpatient survey (Healthcare Commission, 2007a). The 'Patient care overall' indicator, is the response, in percentage terms, to the question in the 2006 national inpatient survey that asks respondents to rate the overall quality of care they received. One of the ultimate tests of hospital board effectiveness should be whether the board positively impacts the quality of patient care. From the evidence presented here, this does not appear to be the case.

Table 4.22 – Correlation of BSAQ scores with key national patient survey and clinical productivity indicators

BSAQ performance dimension	National Patient Survey measures		Clinical productivity measures		
	Patient care ^a	Patient care overall ^a	Pre-op bed days ^b	Length of stay ^b	Day case surgery rates ^b
1. Contextual	.06	.17	-.20	.25	-.06
2. Educational	-.11	-.13	-.24	.21	.27
3. Interpersonal	.04	.05	-.19	.38	.33
4. Analytical	.17	.13	-.38	.18	.21
5. Political	.35	.19	-.19	.12	.23
6. Strategic	.03	.04	-.37	.31	.03
BSAQ Total Score	.07	.06	-.29	.29	.19

^aN=21

^bN=18

Likewise, there appears to be no association between board performance and the following key clinical productivity indicators provided by the NHS Institute for Innovation and Improvement’s ‘NHS Better Care, Better Value Indicator’ programme (NHS Institute, 2007):

- ‘Pre-op bed days’ – i.e. pre-operative bed days. This relates to reducing the amount of time between patients being admitted to hospital and having an operation.
- ‘Length of stay’ – this is one of the greatest variables between NHS hospitals. By reviewing and improving admission and discharge processes, patient experience can be improved and hospital bed days can be saved by reducing the patient’s length of hospital stay, thereby improving efficiency.
- ‘Day case surgery rates’ – hospitals can save money on bed occupancy and nursing care by carrying out elective procedures as day cases where clinical circumstances allow.

Despite there being no apparent statistically significant correlation between BSAQ board performance scores and clinical productivity indicators, it is, perhaps, worthwhile noting that the trends for pre-op bed days and day case surgery rates are in the 'right direction', i.e. there is a negative association between BSAQ scores and pre-op bed days and an overall positive association between BSAQ scores and day case surgery rates. The expectation between BSAQ scores and length of stay would be a negative association, i.e. better performing boards should be associated with reducing length of stay to improve hospital efficiency and, potentially, generate a larger financial surplus. This hypothesis is not, however, supported by the data presented here.

Table 4.23 presents the results of bivariate correlation calculations between BSAQ scores and key national staff survey performance indicators provided by the Healthcare Commission (2007b). One of two salient findings here is that the political dimension of board performance is highly correlated with several of the staff survey indicators (see Figure 4.6). Board performance is positively correlated with quality of work-life balance ($r=.52$, $p=.016$), quality of job design ($r=.59$, $p=.005$), support from immediate managers ($r=.49$, $p=.025$), positive feeling with organisation ($r=.62$, $p=.003$) and job satisfaction ($r=.53$, $p=.014$), and negatively correlated with intention to leave job ($r=.53$, $p=.014$). The political dimension of board performance relates, in part, to the board's linkage with staff (Appendix 3). The results presented here show a strong association between foundation trust boards and staff. In short, trusts with better performing boards on the political dimension have staff who enjoy a better quality of work-life balance, better quality of job design, receive more support from their immediate managers, have a greater sense of positive feeling about the organisation, enjoy greater job satisfaction

Table 4.23 – Correlation of BSAQ scores with key national staff survey performance indicators

BSAQ performance dimension	A	B	C	D	E	F	G	H	I
1. Contextual	.13	-.02	.19	.34	.25	.33	.25	.11	-.22
2. Educational	.38*	.00	-.04	.37*	.19	.06	.08	.12	-.04
3. Interpersonal	.40*	-.05	.08	.42*	.25	.20	.19	.08	-.12
4. Analytical	.34	-.32	.24	.54**	.40*	.39*	.36	-.15	-.30
5. Political	.27	-.20	.52**	.59***	.49**	.62***	.53**	-.11	-.53**
6. Strategic	.28	-.17	.20	.42**	.34	.28	.27	-.07	-.22
BSAQ Total Score	.34	-.13	.20	.50**	.36	.33	.30	-.02	-.25

A = % staff extra hours due to job demands

B = % staff work-related stress last 12 months

C = Quality of work-life balance

D = Quality of job design

E = Support from immediate managers

F = Positive feeling with organisation

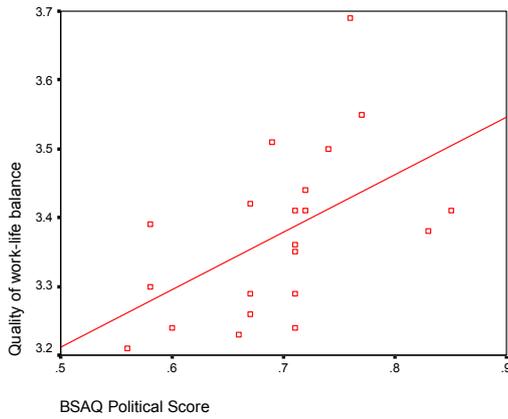
G = Job satisfaction

H = Work pressure

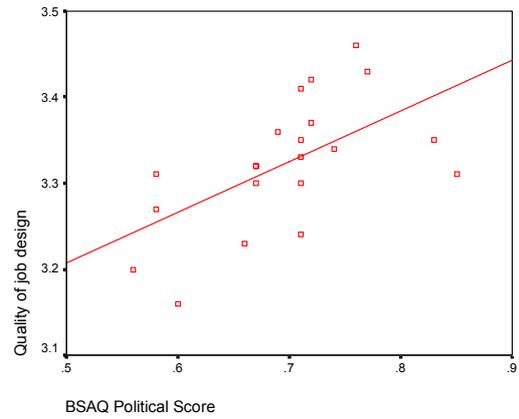
I = Intention to leave job

* p<.1 **p<.05 ***p<.01

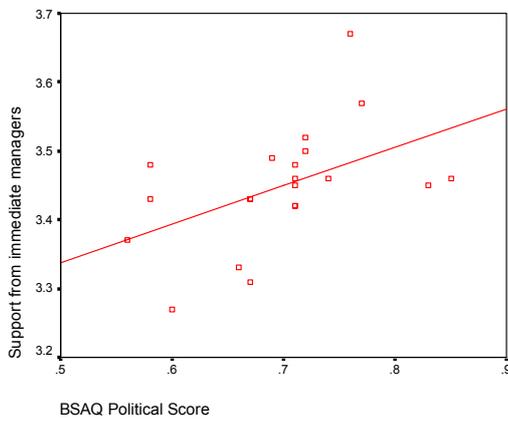
Figure 4.6 – Scatter plots showing BSAQ Political Score against various national staff survey indicators



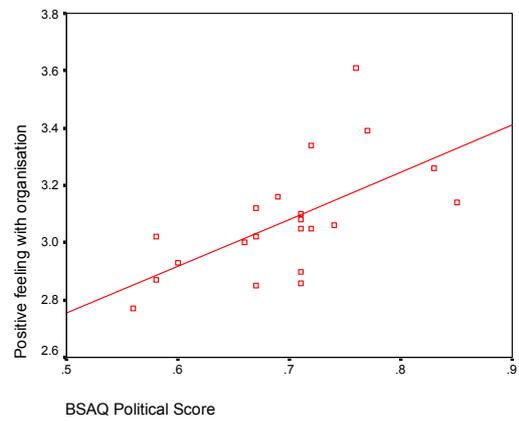
(a) BSAQ Political Score Vs Quality of work-life balance ($r=.52$, $p=.016$)



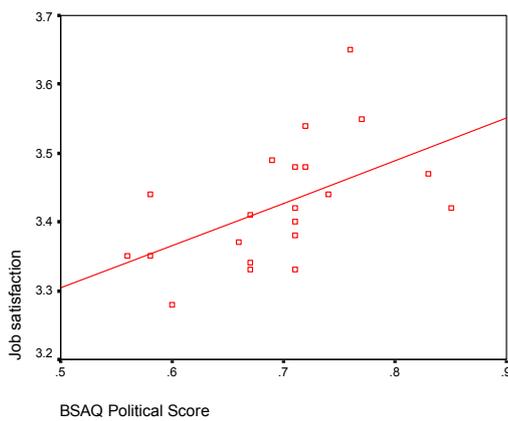
(b) BSAQ Political Score Vs Quality of job design ($r=.59$, $p=.005$)



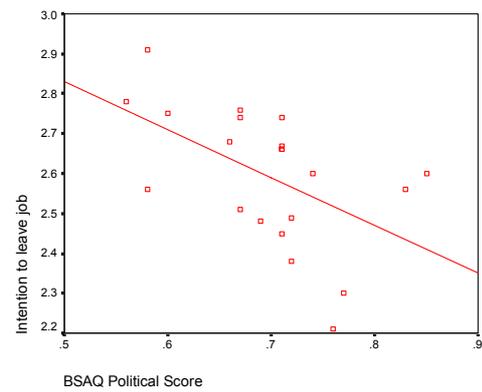
(c) BSAQ Political Score Vs Support from immediate managers ($r=.49$, $p=.025$)



(d) BSAQ Political Score Vs Positive feeling with the organisation ($r=.62$, $p=.003$)



(e) BSAQ Political Score Vs Job satisfaction ($r=.53$, $p=.014$)



(f) BSAQ Political Score Vs Intention to leave job ($r=-.53$, $p=.014$)

and exhibit a lower level of intention to leave their job. Boards that perform better on the political board performance dimension appear better at ‘connecting’ with staff by various means. Staff are any NHS organisation’s principal ‘asset’ and it might be assumed that better performing boards are associated with organisations that realise this and continually strive to create better working conditions for their staff. A case of ‘setting the tone from the top’?

The second salient finding is that most of the board performance dimensions are positively associated with quality of job design and the BSAQ Total Score enjoys a moderately strong correlation with quality of job design ($r=.5$, $p=.021$). NHS foundation trusts put significant effort into improving the quality of services provided to patients and this may account for boards’ association with staff job design. The hypothesis here is that good job design means better service provision for patients. In turn, this should, hypothetically, result in increased patient satisfaction. Unfortunately, this hypothesis is not borne out by the findings in relation to patient care (see Table 4.22) and further research is required to examine the impact of governance practices on patient experience, and also patient clinical outcomes.

4.8 Comparison with USA studies of nonprofit boards

Some comparisons have already been made in this chapter between certain aspects of this study and results from published studies involving nonprofit boards, including hospitals, in the USA (Chait et al., 1993; Jackson and Holland, 1998; and McDonagh, 2005). This section summarises and builds on these comparisons, and extends the comparisons to the work of Brown (2005), who investigated the same six dimensions of effective board performance used in a study involving a sample of over 200 nonprofit

organisations (but not hospitals) in the greater Los Angeles and Phoenix metropolitan area of the United States.

The comparisons made here are in relation to principal research questions 1 and 3 in this study. The second principal research question, which asks “Given the unitary nature of foundation trust boards of directors, is there a difference in perception of board performance between executive and non-executive directors?”, has no basis for comparison with studies of US nonprofit boards. This is because US nonprofit boards are trustee boards, entirely comprised of voluntary, unpaid trustees as board members. This is quite different from the unitary board approach in the NHS, which brings together full time executive directors and part-time, paid non executive directors as, essentially, a ‘professional board.’

i) Research question 1 - Are the six dimensions of effective board performance suggested for nonprofit boards in the USA by Chait, Holland and Taylor (1993) similar in the context of NHS foundation trust boards of directors?

The Board Self-Assessment Questionnaire (BSAQ - Chait et al., 1993) was developed to assess board performance in six areas that previous research had shown to characterise highly effective nonprofit boards. These six areas, or dimensions, reflect underlying contextual, educational, interpersonal, analytical political and strategic constructs related to a 65-item BSAQ instrument (Appendix 2). Brown (2005) used 37 of the 65 BSAQ items to assess board performance in relation to the six dimensions and found that the scales representing each dimension demonstrated sound reliability, and a factor analysis confirmed the existence of a single factor within each dimension. His

overall conclusion was that the six dimensions were “a reasonable framework to explore associations between board and organisational performance.” (Brown, 2005, p325).

McDonagh (2005) tested the efficacy of the BSAQ instrument and its associated six dimensions of effective board performance in 64 nonprofit hospitals in the USA and concluded that the instrument measured a single dominant factor, rather than the six factors representing the board performance dimensions. It is not clear from her work whether she tested, using factor analysis, each of the individual dimensions to check for presence of a single factor within each dimension. Nevertheless, in keeping with her research design, she looked at correlation between the six dimensions and measures of hospital performance in addition to the overall BSAQ score. The overall BSAQ score represented the overarching single construct with which to investigate the relationship between board and organisational performance. She conceded that “It is important to understand the six factors that comprise the general factor so that specific educational focus can be directed at board effectiveness improvement.” (McDonagh, 2005, p87).

The current study found, in relation to data for NHS foundation trust boards of directors, and in line with the findings of Jackson and Holland (1998) and Brown (2005), that the six dimensions provide a valid framework for assessing board performance. In addition, and in line with the findings of McDonagh (2005), the study found an overarching single factor solution to the BSAQ instrument. Thus, the six board performance dimensions, whilst valid and useful as board improvement constructs in their own right, can be consolidated into a single factor of board performance, represented in this study by the ‘BSAQ Total Score.’

Table 4.24 presents mean data for BSAQ scores for the current NHS foundation trust study in relation to the findings of McDonagh (2005) and data representing Jackson and Holland’s ‘BSAQ norms’, based on over 300 US nonprofit boards, including hospitals, reported in McDonagh (2005). Scores for the hospitals are, in the main, significantly higher than the Jackson and Holland norms, which led McDonagh to conclude that either hospitals had been working on improving board effectiveness, or the sample of hospitals she used in her study performed at a higher level compared to the diverse range of nonprofit boards since the Jackson and Holland (1998) study.

Table 4.24 - Comparison of foundation trust BSAQ scores with USA studies

BSAQ performance dimension	BSAQ norms for current NHS foundation trust study (N=21)		McDonagh’s BSAQ norms (US nonprofit hospitals, N=64)		Jackson and Holland’s BSAQ norms (>300 US nonprofit boards)
	M ^a	SD ^a	M ^b	SD ^b	M ^c
1. Contextual	0.68	0.10	0.79	0.12	0.68
2. Educational	0.66	0.11	0.67	0.13	0.53
3. Interpersonal	0.66	0.10	0.73	0.11	0.63
4. Analytical	0.71	0.08	0.70	0.09	0.61
5. Political	0.70	0.08	0.75	0.11	0.64
6. Strategic	0.74	0.10	0.75	0.12	0.65
BSAQ Total Score	0.69	0.08	0.73	0.10	0.62

^a From Table 4.5

^b From McDonagh (2005) Table 5.5

^c From McDonagh (2005) Table 5.5 – no standard deviation data provided

The data for NHS foundation trusts, presented in Table 4.24, indicate, with the exception of the analytical dimension, that trusts exhibit lesser scores than for McDonagh’s US hospitals study. In the case of the contextual dimension, the foundation trust mean score is significantly less. These lesser scores could be because US hospital boards have been around much longer than NHS foundation trust boards (and NHS boards generally). In addition, or alternatively, it may be that the scores in

McDonagh's study are high on account of the fact that 68.8% of her hospitals had only one respondent to the BSAQ survey, and that respondent was the CEO. With a balance of CEO and board trustees responding, the scores could conceivably have been lower.

ii) Research question 3 - Is there an association between board performance, as measured using the BSAQ instrument, and organisational performance in NHS foundation trusts, as defined by publicly available data providing objective measures of financial and non-financial performance?

In all three US studies cited, the authors found statistically significant correlations between board performance, as assessed using the BSAQ tool, or a modified version of the tool, and organisational performance – in particular, financial performance.

Jackson and Holland (1998) found “a moderately strong, statistically significant correlation between the BSAQ's overall average score and the financial reserves indicator ($r=.34$, $p=.05$)” in their study of 34 nonprofit higher education institutions. In addition, they constructed a ‘composite organizational indicator’, or ‘COI’, from a range of indicators and found a “particularly compelling” correlation between overall BSAQ scores and the COI ($r=.35$, $p=.05$). Their conclusion was that “When combined with the overall .79 reliability coefficient [Cronbach's Alpha], the moderate, statistically significant correlation between overall BSAQ scores and the COI offers plausible evidence that board performance, as measured by the BSAQ, and organizational performance are indeed related.”

In his study of 254 nonprofit boards, Brown (2005) found a correlation between overall BSAQ score and net financial surplus ($r=.17$, $p=.008$). He also found a correlation between net financial surplus and the political ($r=.17$, $p=.006$) and strategic ($r=.20$, $p=.001$) dimensions of board performance. No other financial indicators were correlated with board performance. However, he did find in general terms that “strategic contributions of the board are identified as one of the most salient features associated with organizational performance.” This holds for the current study, at least as far as financial performance is concerned.

McDonagh (2005) found higher performing boards had better hospital performance in several dimensions, most notably in profitability and lower expenses. Lower expenses were related to higher scores for the BSAQ total score ($r = -.22$, $p = .09$) and hospital profitability was positively correlated with all six BSAQ dimensions in addition to the BSAQ total score, with the size of the correlations ranging from $r = .25$ to $r = .39$ and an average statistical significance at the $p=.05$ level.

McDonagh (2005) also found correlations between BSAQ scores and aspects of ‘Solucient’s (2004) Top 100 program’. At the time, the Solucient program ranked hospitals in relation to the following 10 metrics: Acute care beds in service; Risk-adjusted mortality rates; Risk-adjusted complication rates; Severity adjusted average length of stay; Coding specificity rates; Expense per adjusted discharge (wage & case mix adjusted); Profitability; Cash flow to debt ratio; Tangible assets per adjusted discharge; and Growth in percent of community served. She found that a more favorable Solucient ranking was significantly related to five variables: (a) hospitals that had a lower score in the BSAQ Political factor, (b) hospitals that had more acute care

beds, (c) hospitals with lower mortality rates, (d) hospitals with greater profitability, and (e) those with more growth in percent community served.

In the NHS there is, currently, no equivalent to the Solucient hospital ranking program in the USA, although specialist organisations such as Dr Foster (see Dr Foster Intelligence, 2007) are looking to improve the utility of data available in the NHS. Consequently, the current study relied on bringing together a range of disparate data sets reflecting organisational performance measures. Significant work is undoubtedly required to improve the availability and quality of data related to organisational performance in the NHS (West, et al., 2002; Kind and Williams, 2004).

Notwithstanding this, however, significant evidence of an association between the performance of boards of directors of NHS foundation trusts and organisational performance was found. Particularly strong and statistically significant correlations were found between all the BSAQ scores (i.e. the six dimensions plus the BSAQ Total Score) and financial performance in terms of surplus. The BSAQ strategic and total scores were found to be particularly strongly correlated with surplus ($r=.73$, $p=.000$ and $r=.66$, $p=.001$, respectively). The BSAQ educational score was found to be correlated with the number of complaints received by the trust ($r=.51$, $p=.019$), although this may be a 'chance' finding given that complaints data for the trusts are very highly correlated with the size of the organisation and controlling for size in terms of income there are no significant correlations between BSAQ scores and complaints data. However, a range of staff-related performance measures were found to be strongly correlated with the BSAQ political dimension, with correlations ranging from $r=.49$ to $r=.62$ and significance levels from $p=.003$ to $p=.025$.

In summary, comparison between correlations of board and organisational performance indicates generally stronger correlations between BSAQ scores and organisational performance indicators in the current NHS foundation trust study as compared with the various US studies examined above.

CHAPTER FIVE – CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This study is the first to systematically explore the factors that measure the performance of boards of directors of NHS foundation trusts and present generalisable empirical evidence of an association between board and organisational performance. It therefore makes an important contribution to the field of corporate governance as it relates to healthcare. The results of this study will be of particular interest to board members in existing and prospective NHS foundation trusts, and of general interest to a broader audience, including boards of other NHS organisations, boards of independent healthcare organisations, regulatory bodies, policy makers and academics.

5.2 Conclusions

From the responses to the supporting questions it is clear that the overwhelming board member perception is that boards significantly impact organisational performance. In addition, board members believe that organisational success is increasingly in the hands of the board, reflecting the fact that NHS foundation trusts, substantially freed from central government control, are becoming more confident that they, rather than ministers and civil servants, are in control of their organisations.

The following conclusions can be drawn from the results of addressing the three principal research questions presented in chapter 4:

1. The six dimensions of effective board performance suggested for nonprofit boards in the USA by Chait, Holland and Taylor (1993) are similar in the context of NHS foundation trust boards of directors. Thus, both they and the Board Self-Assessment Questionnaire (BSAQ), an extensively researched and tested instrument originating in the USA from which the six dimensions are derived, can be assumed to provide reliable, valid and sensitive measures of board performance. This has potentially significant implications for improving board and organisational performance.

2. In the unitary make-up of foundation trust boards of directors, there appears to be no significant difference in perception of board performance between executive and non-executive directors. This suggests that foundation trust boards operate as collaborative, cohesive teams in accordance with good governance practice. This type of board functioning can only serve to ensure a good foundation for building a high performance board and organisation.

3. There is an association between the performance of the boards of directors of the NHS foundation trusts participating in this study and a number of dimensions of organisational performance. In particular, there are strong and highly significant correlations between board performance, as measured using the BSAQ instrument, measures of financial performance, and measures of staff satisfaction derived from the annual national staff survey. Unfortunately, no evidence of an association between board performance and patient outcomes or experience was established, and this requires further investigation. Nevertheless, from the evidence presented in this dissertation, it would appear that boards can

and do make a difference. Whilst correlation does not imply causation, nevertheless gains in board performance do appear to relate to improvements in organisational performance. Therefore, working to improve the performance of boards of directors offers an opportunity to achieve significant gains in terms of strengthening the overall performance of the organisation for relatively minimal effort (Jackson and Holland, 1998).

In short, the findings from this study strongly suggest that high performing foundation trust boards of directors are associated with high performing trusts.

5.3 Recommendations

Recommendations are made in relation to the following three key audiences: boards of NHS foundation trusts and other healthcare organisations; policy makers and regulators; and those interested in academic research related to corporate governance in healthcare.

i) For boards of NHS foundation trusts and other healthcare organisations

Boards, if not already doing so, should engage in a programme of ongoing development and improvement using well tested, evidence-based tools. The BSAQ instrument used in this study is one example of such a tool, and one that can inexpensively be utilised to improve board and organisational performance.

Chait, Holland and Taylor (1996, p16) write of their experiences of practical lessons learned in applying the tool in a board development context, which are extremely useful to boards considering, or engaged in development activity. Their experiences are, therefore, summarised here:

1. Board development activity cannot be imposed – the entire board must acknowledge the importance of effective governance and must be committed to improving proficiency through board development.
2. Board members cannot be asked to do “the real work” of the board and then do board development. Board development must be embedded in all aspects of board activity and must be seen to be advantageous in both enabling the board to work better and in producing results that are beneficial to the organisation.
3. It is easier to change a board’s behaviour through system and process changes that enable board members to act differently, than through exhortation.
4. Relatively small and simple changes in board structure, process and procedures can result in significant, positive impact on board behaviour. For example, the process of creating a set of critical performance indicators can both educate board members and build group cohesion, as well as generating a substantive board product.
5. Like any form of professional or organisational development, board development must be approached as an intensive, long term process and not a quick-fix. Sustained improvement comes from solid, ongoing commitment to the process by board member ‘champions’ of board development.

ii) For policy makers and regulators

Setting aside the differences in key roles between healthcare policy makers and regulators, and, instead, focusing on ‘common ground’ between the two, it is clearly in the best interests of both, and ultimately, patients and society as a whole, to ensure healthcare organisations perform at the highest possible level. Given the association between board and organisational performance, policy makers and regulators should give maximum possible encouragement and guidance to boards in relation to improving board performance. Given their overarching remit, they should also review the need and funding for research in corporate governance and its association with performance in healthcare (see iii, below).

iii) For those interested in researching the relationship between board governance and organisational performance in healthcare

There can be no question that substantially more good research is needed in this area. According to Carver (2006, p. 319), “Compared with research in managerial and technical subjects, governance research continues in a primitive state despite the great increase in studies over the past couple of decades.” His unequivocal belief is that boards exist to translate owners’ intentions into organisational performance. Given this, he is clear that “the central and even foundational research inquiry is to find which governance practices are best able to convert a judicious summary of owners’ intentions into organizational performance.” (Carver, 2006, p 339). He concedes, however, that whilst the question is simple, researching it is not.

Adopting Carver's philosophy and reflecting on the results of this study, three principal areas of research inquiry related to corporate governance in healthcare are recommended:

1. There needs to be a better understanding of the needs of 'owners' of healthcare organisations (see Figure 1.1) and how these needs translate into an acceptable (to all stakeholders) system of organisational performance indicators for measurement, monitoring and improvement purposes.
2. There needs to be a 'bringing together' and understanding of the specific governance practices that could positively impact board and organisational performance. Understanding board members' perceptions of what constitutes good governance practice and its relationship with organisational performance in highly performing boards through detailed interviews would be of value. Particular attention should be given to identifying those governance practices that impact patient outcome, or 'clinical' indicators and also satisfaction indicators.
3. There need to be longitudinal studies focusing on the improvements in organisational performance resulting from implementing, in a systematic and controlled manner, identified governance practices.

Implementing these three recommendations would address Lockhart's (2005) issue of determining causality, and would enable governance research to evolve beyond what Carver (2006) contends is currently a "primitive state."

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APPENDIX 1 – The six dimensions, or competencies, of effective nonprofit board performance. Adapted from Chait et al., 1993, p2.

1. *Contextual dimension.* The board understands and takes into account the culture, values and norms of the organisation it governs. The board:
 - 1.1. Adapts to the distinctive characteristics and culture of the organisation's environment
 - 1.2. Relies on the institution's mission, values, and traditions as a guide for decisions
 - 1.3. Acts so as to exemplify and reinforce the organisation's core values
2. *Educational dimension.* The board takes the necessary steps to ensure that all board members are well-informed about the organisation and the professions working there as well as the board's own roles, responsibilities and performance. The board:
 - 2.1. consciously creates opportunities for board member education and development.
 - 2.2. Regularly seeks information and feedback on its own performance.
 - 2.3. Pauses periodically for self-reflection, to diagnose its strengths and limitations, and to examine its mistakes.
3. *Interpersonal dimension.* The board nurtures the development of board members *as a group* (original emphasis), attends to the board's *collective* (original emphasis) welfare, and fosters a sense of cohesiveness. The board:
 - 3.1. Creates a sense of inclusiveness among board members.
 - 3.2. Develops group goals and recognises group achievements.
 - 3.3. Identifies and cultivates leadership within the board.
4. *Analytical dimension.* The board recognises complexities and subtleties in the issues it faces and draws upon multiple perspectives to dissect complex problems and to synthesise appropriate responses. The board:
 - 4.1. Approaches problems from a broad organisational outlook.
 - 4.2. Searches widely for concrete information and actively seeks different viewpoints from multiple constituencies/stakeholders.
 - 4.3. Tolerates ambiguity and recognises that complex matters rarely yield to perfect solutions.
5. *Political dimension.* The board accepts as one of its primary responsibilities the need to develop and maintain healthy relationships among key stakeholders. The board:
 - 5.1. Respects the integrity of the governance process and the legitimate role and responsibilities of other stakeholders.
 - 5.2. Consults often and communicates directly with key stakeholders.
 - 5.3. Attempts to minimise conflict and 'win/lose' situations.
6. *Strategic dimension.* The board helps envision and shape institutional direction and helps ensure a strategic approach to the organisation's future. The board:
 - 6.1. Cultivates and concentrates on processes that sharpen organisational priorities.
 - 6.2. Directs its attention to priorities or decisions of strategic or symbolic magnitude to the organisation.
 - 6.3. Anticipates potential problems and acts before issues become urgent.

APPENDIX 2 – Survey tool incorporating Board Self-Assessment Questionnaire (BSAQ)

This confidential research study seeks to understand more about boards of directors in NHS Foundation Trusts (“the board”), and how the board influences organisational performance. This survey solicits opinions from board members to find out what your perspectives are about your board and linkages between FT boards of directors and organisational performance. Responding to the survey should take around 15-20 minutes of your time and your participation will assist greatly in providing valuable knowledge to the important and growing field of healthcare governance.

All information that you provide over the Internet is done so using a secure, encrypted connection. The information obtained for this research will remain confidential. Only the researcher is able to access the information through a password-protected database. To further protect confidentiality, no data about you as an individual are requested. The name of your trust is required so that an overall trust score can be computed, but this will be anonymised in the final report.

If you have questions about this study, please feel free to contact the researcher, Stuart Emslie, on S.Emslie@lboro.ac.uk

Section A - Background

1. Would you like your board to receive a free confidential 'benchmarking' report that compares your board and organisational performance in relation to the anonymised results from all other participating foundation trusts? If you do, it will be sent to the Chair and CEO.

- Yes
- No

2. Please select your organisation from the list.

3. Are you an executive or non-executive board member?

4. To what extent do you feel your board influences, or impacts, the performance of the organisation?

	Very small	Small	Moderate	Large	Very large
Impact					

5. From whom would you say that your board derives its authority? Tick one box only.

Board of Governors	
Department of Health	
Monitor	
Patients and Public	
Other (Specify)	

6. To what extent do you feel that the success of the organisation is in the hands of the board today; to what extent was it five years ago; and to what extent do you expect it to be in five years time?

	Very small	Small	Moderate	Large	Very large
Today					
5 years ago					
In 5 years time					

Section B –Statements on board effectiveness

For each statement below, please indicate your strength of agreement.

		Strongly Agree	Agree	Disagree	Strongly Disagree
1.	This board takes regular steps to keep itself informed about important trends in the local health economy, and in the wider national healthcare environment, that might affect the organisation.				
2.	I have participated in board discussions about what we should do differently as a result of a mistake the board made.				
3.	I have had conversations with other members of this board regarding common interests we share outside this organisation				
4.	I have been in board meetings where it seemed that the subtleties of the issues we dealt with escaped the awareness of a number of the members.				
5.	Our board explicitly examines the “downside” or possible pitfalls of any important decisions it is about to make.				
6.	Induction programmes for new board members, particularly non executives, specifically include a segment about both the NHS and the organisation’s history and traditions.				
7.	This board is more involved in trying to put out fires than in preparing for the future.				
8.	The board sets clear organisational priorities for the year ahead.				
9.	This board communicates its decisions to all those who are affected by them.				
10.	At least once every two years, our board has a retreat or special session to examine our performance, how well we are doing as a board.				
11.	Many of the issues that this board deals with seem to be separate tasks, unrelated to one another.				
12.	In discussing key issues, it is not unusual for someone on the board to talk about what this organisation stands for and how that is related to the matter at hand.				
13.	Values are seldom discussed explicitly at our board meetings.				
14.	If our board thinks that an important internal or external stakeholder or stakeholder group is likely to disagree with an action we are considering, we will make sure we learn how they feel before we actually make the decision.				

		Strongly Agree	Agree	Disagree	Strongly Disagree
15.	Differences of opinion in board decisions are more often settled by vote than by more discussion.				
16.	This board delays action until an issue becomes urgent or critical.				
17.	This board periodically sets aside time to learn more about important issues facing NHS Foundation Trusts.				
18.	I can recall an occasion when the board acknowledged its responsibility for an ill-advised decision.				
19.	This board has formed ad hoc committees or task forces that include staff as well as board members.				
20.	This board is as attentive to how it reaches conclusions as it is to what is decided.				
21.	Most people on this board tend to rely on observation and informal discussions to learn about their role and responsibilities.				
22.	I find it easy to identify the key issues that this board faces.				
23.	When faced with an important issue, the board often “brainstorms” and tries to generate a whole list of creative approaches or solutions to the problem.				
24.	When a new member joins this board, we make sure that someone serves as a mentor to help this person learn the ropes.				
25.	I have been in board meetings where explicit attention was given to the concerns of the local community.				
26.	I have participated in board discussions about the effectiveness of our performance.				
27.	At our board meetings, there is at least as much dialogue among non executive members as there is between non executive members and executive members.				
28.	When issues come before our board, they are seldom framed in a way that enables members to see the connections between the matter at hand and the organisation’s overall strategy.				
29.	I have participated in discussions with new board members about the roles and responsibilities of a board member.				
30.	This board has made a key decision that I believe to be inconsistent with the mission of this organisation.				

		Strongly Agree	Agree	Disagree	Strongly Disagree
31.	The leadership of this board typically goes out of its way to make sure that all members have the same information on important issues.				
32.	This board has adopted some explicit goals for itself, distinct from goals it has for the total organisation.				
33.	The board periodically requests information on the morale of the professional staff.				
34.	I have participated in board discussions about what we can learn from a mistake we have made				
35.	Our board meetings tend to focus more on current concerns than on preparing for the future.				
36.	At least once a year, this board asks that the chief executive articulate his/her vision for the organisation's future and strategies to realise that vision.				
37.	I have been present in board meetings where discussions of the history and mission of the organisation were key factors in reaching a conclusion on a problem.				
38.	I have never received feedback on my performance as a member of this board.				
39.	It is apparent from the comments of some of our board members that they do not understand the mission of the organisation very well.				
40.	This board has on occasion evaded responsibility for some important issue facing the organisation.				
41.	Before reaching a decision on important issues, this board usually requests input from persons likely to be affected by the decision.				
42.	There have been occasions where the board itself has acted in ways inconsistent with the organisation's deepest values.				
43.	This board relies on the natural emergence of leaders, rather than trying explicitly to cultivate future leaders for the board.				
44.	This board often discusses where the organisation should be headed five or more years into the future.				
45.	New members are provided with a detailed explanation of this organisation's mission when they join this board.				
46.	This board does not allocate organisational funds for the purpose of board education and development.				

		Strongly Agree	Agree	Disagree	Strongly Disagree
47.	Recommendations from the executive directors are usually accepted with little questioning in board meetings.				
48.	At times this board has appeared unaware of the impact its decisions will have within our local community.				
49.	Within the past year, this board has reviewed the organisation's strategies for attaining its long-term goals.				
50.	This board reviews the organisation's mission at periodic intervals.				
51.	This board has conducted an explicit examination of its roles and responsibilities.				
52.	I am able to speak my mind on key issues without fear that I will be ostracised by some members of this board.				
53.	This board tries to avoid issues that are ambiguous and complicated.				
54.	The executive directors rarely report to the board on the concerns of patients.				
55.	I have been in board meetings where the discussion focused on identifying or overcoming the organisation's weakness.				
56.	One of the reasons I joined this board was that I believe strongly in the values of this organisation.				
57.	This board does not recognise special events in the lives of its members.				
58.	The board discusses events and trends in the larger environment that may present specific opportunities for this organisation.				
59.	Former members of this board have participated in special events designed to convey to new members the organisation's history and values.				
60.	This board provides biographical information that helps members get to know one another better.				
61.	This board seeks information and advice from leaders of other similar organisations.				
62.	This board makes explicit use of the long range priorities of this organisation in dealing with current issues.				
63.	This board understands the norms of the professions working in this organisation.				
64.	This board meets socially as a group.				
65.	More than half of this board's time is spent in discussions of issues of importance to the organisation's long-range future.				

APPENDIX 3 – Board Self-Assessment Questionnaire (BSAQ) – question items arranged by board performance dimensions, or competencies (contextual, educational, interpersonal, analytical, political, strategic)

Items in italics are reverse scored.

Competency 1: Understands context (Contextual)	
6.	Induction programmes for new board members, particularly non executives, specifically include a segment about both the NHS and the organisation’s history and traditions.
12.	In discussing key issues, it is not unusual for someone on the board to talk about what this organisation stands for and how that is related to the matter at hand.
13.	<i>Values are seldom discussed explicitly at our board meetings.</i>
30.	<i>This board has made a key decision that I believe to be inconsistent with the mission of this organisation.</i>
37.	I have been present in board meetings where discussions of the history and mission of the organisation were key factors in reaching a conclusion on a problem.
39.	<i>It is apparent from the comments of some of our board members that they do not understand the mission of the organisation very well.</i>
42.	<i>There have been occasions where the board itself has acted in ways inconsistent with the organisation’s deepest values.</i>
45.	New members are provided with a detailed explanation of this organisation’s mission when they join this board.
50.	This board reviews the organisation’s mission at periodic intervals.
56.	One of the reasons I joined this board was that I believe strongly in the values of this organisation.
59.	Former members of this board have participated in special events designed to convey to new members the organisation’s history and values.
63.	This board understands the norms of the professions working in this organisation.

Competency 2: Builds learning (Educational)	
2.	I have participated in board discussions about what we should do differently as a result of a mistake the board made.
10.	At least once every two years, our board has a retreat or special session to examine our performance, how well we are doing as a board.
17.	This board periodically sets aside time to learn more about important issues facing NHS Foundation Trusts.
18.	I can recall an occasion when the board acknowledged its responsibility for an ill-advised decision.
21.	<i>Most people on this board tend to rely on observation and informal discussions to learn about their role and responsibilities.</i>
24.	When a new member joins this board, we make sure that someone serves as a mentor to help this person learn the ropes.
26.	I have participated in board discussions about the effectiveness of our performance.
29.	I have participated in discussions with new board members about the roles and responsibilities of a board member.
34.	I have participated in board discussions about what we can learn from a mistake we have made
38.	<i>I have never received feedback on my performance as a member of this board.</i>
46.	<i>This board does not allocate organisational funds for the purpose of board education and development.</i>
51.	This board has conducted an explicit examination of its roles and responsibilities.

Competency 3: Nurtures group (Interpersonal)	
3.	I have had conversations with other members of this board regarding common interests we share outside this organisation
15.	<i>Differences of opinion in board decisions are more often settled by vote than by more discussion.</i>
20.	This board is as attentive to how it reaches conclusions as it is to what is decided.
27.	At our board meetings, there is at least as much dialogue among non executive members as there is between non executive members and executive members.
31.	The leadership of this board typically goes out of its way to make sure that all members have the same information on important issues.
32.	This board has adopted some explicit goals for itself, distinct from goals it has for the total organisation.
43.	<i>This board relies on the natural emergence of leaders, rather than trying explicitly to cultivate future leaders for the board.</i>
52.	I am able to speak my mind on key issues without fear that I will be ostracised by some members of this board.
57.	<i>This board does not recognise special events in the lives of its members.</i>
60.	This board provides biographical information that helps members get to know one another better.
64.	This board meets socially as a group.

Competency 4: Recognises complexity (Analytical)	
1.	This board takes regular steps to keep itself informed about important trends in the local health economy, and in the wider national healthcare environment, that might affect the organisation.
4.	<i>I have been in board meetings where it seemed that the subtleties of the issues we dealt with escaped the awareness of a number of the members.</i>
5.	Our board explicitly examines the “downside” or possible pitfalls of any important decisions it is about to make.
11.	<i>Many of the issues that this board deals with seem to be separate tasks, unrelated to one another.</i>
22.	I find it easy to identify the key issues that this board faces.
23.	When faced with an important issue, the board often “brainstorms” and tries to generate a whole list of creative approaches or solutions to the problem.
28.	<i>When issues come before our board, they are seldom framed in a way that enables members to see the connections between the matter at hand and the organisation’s overall strategy.</i>
47.	<i>Recommendations from the executive directors are usually accepted with little questioning in board meetings.</i>
53.	<i>This board tries to avoid issues that are ambiguous and complicated.</i>
61.	This board seeks information and advice from leaders of other similar organisations.

Competency 5: Respects process (Political)	
9.	This board communicates its decisions to all those who are affected by them.
14.	If our board thinks that an important internal or external stakeholder or stakeholder group is likely to disagree with an action we are considering, we will make sure we learn how they feel before we actually make the decision.
19.	This board has formed ad hoc committees or task forces that include staff as well as board members.
25.	I have been in board meetings where explicit attention was given to the concerns of the local community.
33.	The board periodically requests information on the morale of the professional staff.
41.	Before reaching a decision on important issues, this board usually requests input from persons likely to be affected by the decision.
48.	<i>At times this board has appeared unaware of the impact its decisions will have within our local community.</i>
54.	<i>The executive directors rarely report to the board on the concerns of patients.</i>

Competency 6: Shapes direction (Strategic)	
7.	<i>This board is more involved in trying to put out fires than in preparing for the future.</i>
8.	The board sets clear organisational priorities for the year ahead.
16.	<i>This board delays action until an issue becomes urgent or critical.</i>
35.	<i>Our board meetings tend to focus more on current concerns than on preparing for the future.</i>
36.	At least once a year, this board asks that the chief executive articulate his/her vision for the organisation's future and strategies to realise that vision.
40.	<i>This board has on occasion evaded responsibility for some important issue facing the organisation.</i>
44.	This board often discusses where the organisation should be headed five or more years into the future.
49.	Within the past year, this board has reviewed the organisation's strategies for attaining its long-term goals.
55.	I have been in board meetings where the discussion focused on identifying or overcoming the organisation's weakness.
58.	The board discusses events and trends in the larger environment that may present specific opportunities for this organisation.
62.	This board makes explicit use of the long range priorities of this organisation in dealing with current issues.
65.	More than half of this board's time is spent in discussions of issues of importance to the organisation's long-range future.

APPENDIX 4 - Board Self Assessment Questionnaire (BSAQ): responses from all board members sorted by highest mean

Items in italics are reverse scored.

C*	Q	Question Item	M	SD
3	15	<i>Differences of opinion in board decisions are more often settled by vote than by more discussion.</i>	2.70	0.49
3	52	I am able to speak my mind on key issues without fear that I will be ostracised by some members of this board.	2.52	0.70
4	1	This board takes regular steps to keep itself informed about important trends in the local health economy, and in the wider national healthcare environment, that might affect the organisation.	2.51	0.55
2	26	I have participated in board discussions about the effectiveness of our performance.	2.46	0.73
1	56	One of the reasons I joined this board was that I believe strongly in the values of this organisation.	2.44	0.64
6	16	<i>This board delays action until an issue becomes urgent or critical.</i>	2.41	0.57
6	40	<i>This board has on occasion evaded responsibility for some important issue facing the organisation.</i>	2.38	0.69
4	5	Our board explicitly examines the “downside” or possible pitfalls of any important decisions it is about to make.	2.37	0.56
6	49	Within the past year, this board has reviewed the organisation’s strategies for attaining its long-term goals.	2.33	0.71
4	53	<i>This board tries to avoid issues that are ambiguous and complicated.</i>	2.33	0.71
5	54	<i>The executive directors rarely report to the board on the concerns of patients.</i>	2.33	0.71
4	22	I find it easy to identify the key issues that this board faces.	2.32	0.57
6	8	The board sets clear organisational priorities for the year ahead.	2.30	0.65
3	31	The leadership of this board typically goes out of its way to make sure that all members have the same information on important issues.	2.29	0.72
6	7	<i>This board is more involved in trying to put out fires than in preparing for the future.</i>	2.28	0.59
2	38	<i>I have never received feedback on my performance as a member of this board.</i>	2.28	0.90
1	50	This board reviews the organisation’s mission at periodic intervals.	2.25	0.67
5	25	I have been in board meetings where explicit attention was given to the concerns of the local community.	2.24	0.46
1	39	<i>It is apparent from the comments of some of our board members that they do not understand the mission of the organisation very well.</i>	2.23	0.68
1	42	<i>There have been occasions where the board itself has acted in ways inconsistent with the organisation’s deepest values.</i>	2.23	0.65
6	58	The board discusses events and trends in the larger environment that may present specific opportunities for this organisation.	2.23	0.54
4	47	<i>Recommendations from the executive directors are usually accepted with little questioning in board meetings.</i>	2.22	0.59
1	30	<i>This board has made a key decision that I believe to be inconsistent with the mission of this organisation.</i>	2.21	0.66
5	48	<i>At times this board has appeared unaware of the impact its decisions will have within our local community.</i>	2.18	0.53
2	51	This board has conducted an explicit examination of its roles and responsibilities.	2.16	0.72
6	55	I have been in board meetings where the discussion focused on identifying or overcoming the organisation’s weakness.	2.13	0.62
3	27	At our board meetings, there is at least as much dialogue among non executive members as there is between non executive members and executive members.	2.09	0.74
5	9	This board communicates its decisions to all those who are affected by them.	2.08	0.62

C*	Q	Question Item	M	SD
1	63	This board understands the norms of the professions working in this organisation.	2.08	0.56
6	62	This board makes explicit use of the long range priorities of this organisation in dealing with current issues.	2.05	0.57
2	10	At least once every two years, our board has a retreat or special session to examine our performance, how well we are doing as a board.	2.04	0.93
4	11	<i>Many of the issues that this board deals with seem to be separate tasks, unrelated to one another.</i>	2.04	0.61
6	36	At least once a year, this board asks that the chief executive articulate his/her vision for the organisation's future and strategies to realise that vision.	2.04	0.72
1	45	New members are provided with a detailed explanation of this organisation's mission when they join this board.	2.04	0.66
3	3	I have had conversations with other members of this board regarding common interests we share outside this organisation	1.99	0.67
5	19	This board has formed ad hoc committees or task forces that include staff as well as board members.	1.99	0.58
4	61	This board seeks information and advice from leaders of other similar organisations.	1.98	0.63
4	28	When issues come before our board, they are seldom framed in a way that enables members to see the connections between the matter at hand and the organisation's overall strategy.	1.97	0.62
2	29	I have participated in discussions with new board members about the roles and responsibilities of a board member.	1.97	0.73
2	17	This board periodically sets aside time to learn more about important issues facing NHS Foundation Trusts.	1.92	0.62
1	13	<i>Values are seldom discussed explicitly at our board meetings.</i>	1.91	0.58
5	33	The board periodically requests information on the morale of the professional staff.	1.90	0.59
6	35	<i>Our board meetings tend to focus more on current concerns than on preparing for the future.</i>	1.89	0.66
1	6	Induction programmes for new board members, particularly non executives, specifically include a segment about both the NHS and the organisation's history and traditions.	1.88	0.70
6	44	This board often discusses where the organisation should be headed five or more years into the future.	1.86	0.89
2	46	<i>This board does not allocate organisational funds for the purpose of board education and development.</i>	1.86	0.76
5	14	If our board thinks that an important internal or external stakeholder or stakeholder group is likely to disagree with an action we are considering, we will make sure we learn how they feel before we actually make the decision.	1.84	0.59
2	2	I have participated in board discussions about what we should do differently as a result of a mistake the board made.	1.82	0.68
1	12	In discussing key issues, it is not unusual for someone on the board to talk about what this organisation stands for and how that is related to the matter at hand.	1.82	0.64
3	20	This board is as attentive to how it reaches conclusions as it is to what is decided.	1.82	0.55
2	34	I have participated in board discussions about what we can learn from a mistake we have made	1.80	0.72
3	57	<i>This board does not recognise special events in the lives of its members.</i>	1.80	0.77
2	21	<i>Most people on this board tend to rely on observation and informal discussions to learn about their role and responsibilities.</i>	1.78	0.57
6	65	More than half of this board's time is spent in discussions of issues of importance to the organisation's long-range future.	1.78	0.75
1	37	I have been present in board meetings where discussions of the history and mission of the organisation were key factors in reaching a conclusion on a problem.	1.77	0.66

C*	Q	Question Item	M	SD
5	41	Before reaching a decision on important issues, this board usually requests input from persons likely to be affected by the decision.	1.77	0.60
3	60	This board provides biographical information that helps members get to know one another better.	1.74	0.65
4	23	When faced with an important issue, the board often “brainstorms” and tries to generate a whole list of creative approaches or solutions to the problem.	1.54	0.71
4	4	<i>I have been in board meetings where it seemed that the subtleties of the issues we dealt with escaped the awareness of a number of the members.</i>	1.53	0.73
3	32	This board has adopted some explicit goals for itself, distinct from goals it has for the total organisation.	1.52	0.68
3	43	<i>This board relies on the natural emergence of leaders, rather than trying explicitly to cultivate future leaders for the board.</i>	1.47	0.67
2	24	When a new member joins this board, we make sure that someone serves as a mentor to help this person learn the ropes.	1.45	0.73
2	18	I can recall an occasion when the board acknowledged its responsibility for an ill-advised decision.	1.35	0.62
3	64	This board meets socially as a group.	1.32	0.76
1	59	Former members of this board have participated in special events designed to convey to new members the organisation’s history and values.	1.21	0.59

*C1=contextual, C2=educational, C3=interpersonal, C4=analytical, C5=political, C6=strategic

APPENDIX 5 – Board Self Assessment Questionnaire (BSAQ) – responses from executive directors (N=42) sorted by highest mean.

Items in italics are reverse scored.

<i>C*</i>		Question Item	M	SD
3	15	Differences of opinion in board decisions are more often settled by vote than by more discussion.	2.76	0.43
2	26	I have participated in board discussions about the effectiveness of our performance.	2.52	0.74
4	1	This board takes regular steps to keep itself informed about important trends in the local health economy, and in the wider national healthcare environment, that might affect the organisation.	2.48	0.55
3	52	I am able to speak my mind on key issues without fear that I will be ostracised by some members of this board.	2.45	0.71
5	54	The executive directors rarely report to the board on the concerns of patients.	2.43	0.70
1	56	One of the reasons I joined this board was that I believe strongly in the values of this organisation.	2.40	0.66
4	5	Our board explicitly examines the “downside” or possible pitfalls of any important decisions it is about to make.	2.33	0.61
6	16	This board delays action until an issue becomes urgent or critical.	2.33	0.53
4	22	I find it easy to identify the key issues that this board faces.	2.33	0.61
6	49	Within the past year, this board has reviewed the organisation’s strategies for attaining its long-term goals.	2.33	0.72
6	8	The board sets clear organisational priorities for the year ahead.	2.31	0.68
1	50	This board reviews the organisation’s mission at periodic intervals.	2.31	0.68
1	30	This board has made a key decision that I believe to be inconsistent with the mission of this organisation.	2.29	0.64
4	53	This board tries to avoid issues that are ambiguous and complicated.	2.29	0.71
5	25	I have been in board meetings where explicit attention was given to the concerns of the local community.	2.26	0.45
6	40	This board has on occasion evaded responsibility for some important issue facing the organisation.	2.26	0.70
6	7	This board is more involved in trying to put out fires than in preparing for the future.	2.21	0.52
3	31	The leadership of this board typically goes out of its way to make sure that all members have the same information on important issues.	2.21	0.78
6	58	The board discusses events and trends in the larger environment that may present specific opportunities for this organisation.	2.21	0.52
2	38	I have never received feedback on my performance as a member of this board.	2.19	0.99
5	48	At times this board has appeared unaware of the impact its decisions will have within our local community.	2.12	0.50
1	42	There have been occasions where the board itself has acted in ways inconsistent with the organisation’s deepest values.	2.11	0.68
1	39	It is apparent from the comments of some of our board members that they do not understand the mission of the organisation very well.	2.10	0.66
1	45	New members are provided with a detailed explanation of this organisation’s mission when they join this board.	2.10	0.69
4	47	Recommendations from the executive directors are usually accepted with little questioning in board meetings.	2.10	0.66
6	55	I have been in board meetings where the discussion focused on identifying or overcoming the organisation’s weakness.	2.10	0.58
2	29	I have participated in discussions with new board members about the roles and responsibilities of a board member.	2.07	0.75
4	28	When issues come before our board, they are seldom framed in a way that enables members to see the connections between the matter at hand and the organisation’s overall strategy.	2.02	0.47
2	51	This board has conducted an explicit examination of its roles and responsibilities.	2.02	0.81

C*	Question Item	M	SD
2 17	This board periodically sets aside time to learn more about important issues facing NHS Foundation Trusts.	2.01	0.61
6 62	This board makes explicit use of the long range priorities of this organisation in dealing with current issues.	2.01	0.61
5 9	This board communicates its decisions to all those who are affected by them.	2.00	0.66
2 10	At least once every two years, our board has a retreat or special session to examine our performance, how well we are doing as a board.	2.00	0.99
3 27	At our board meetings, there is at least as much dialogue among non executive members as there is between non executive members and executive members.	2.00	0.73
6 36	At least once a year, this board asks that the chief executive articulate his/her vision for the organisation's future and strategies to realise that vision.	2.00	0.70
5 19	This board has formed ad hoc committees or task forces that include staff as well as board members.	1.98	0.60
4 61	This board seeks information and advice from leaders of other similar organisations.	1.98	0.60
1 63	This board understands the norms of the professions working in this organisation.	1.98	0.64
1 6	Induction programmes for new board members, particularly non executives, specifically include a segment about both the NHS and the organisation's history and traditions.	1.94	0.66
2 2	I have participated in board discussions about what we should do differently as a result of a mistake the board made.	1.93	0.64
2 46	This board does not allocate organisational funds for the purpose of board education and development.	1.93	0.78
3 3	I have had conversations with other members of this board regarding common interests we share outside this organisation	1.90	0.76
4 11	Many of the issues that this board deals with seem to be separate tasks, unrelated to one another.	1.90	0.48
6 35	Our board meetings tend to focus more on current concerns than on preparing for the future.	1.90	0.53
1 13	Values are seldom discussed explicitly at our board meetings.	1.88	0.59
5 14	If our board thinks that an important internal or external stakeholder or stakeholder group is likely to disagree with an action we are considering, we will make sure we learn how they feel before we actually make the decision.	1.86	0.57
5 41	Before reaching a decision on important issues, this board usually requests input from persons likely to be affected by the decision.	1.86	0.52
5 33	The board periodically requests information on the morale of the professional staff.	1.83	0.58
6 44	This board often discusses where the organisation should be headed five or more years into the future.	1.83	0.88
1 12	In discussing key issues, it is not unusual for someone on the board to talk about what this organisation stands for and how that is related to the matter at hand.	1.81	0.59
1 37	I have been present in board meetings where discussions of the history and mission of the organisation were key factors in reaching a conclusion on a problem.	1.81	0.71
2 34	I have participated in board discussions about what we can learn from a mistake we have made	1.79	0.72
2 21	Most people on this board tend to rely on observation and informal discussions to learn about their role and responsibilities.	1.76	0.58
3 57	This board does not recognise special events in the lives of its members.	1.76	0.82
6 65	More than half of this board's time is spent in discussions of issues of importance to the organisation's long-range future.	1.76	0.73
3 60	This board provides biographical information that helps members get to know one another better.	1.74	0.73
3 20	This board is as attentive to how it reaches conclusions as it is to what is decided.	1.71	0.55

C*		Question Item	M	SD
3	43	This board relies on the natural emergence of leaders, rather than trying explicitly to cultivate future leaders for the board.	1.55	0.71
2	24	When a new member joins this board, we make sure that someone serves as a mentor to help this person learn the ropes.	1.48	0.67
4	23	When faced with an important issue, the board often “brainstorms” and tries to generate a whole list of creative approaches or solutions to the problem.	1.40	0.63
2	18	I can recall an occasion when the board acknowledged its responsibility for an ill-advised decision.	1.38	0.62
3	32	This board has adopted some explicit goals for itself, distinct from goals it has for the total organisation.	1.38	0.62
4	4	I have been in board meetings where it seemed that the subtleties of the issues we dealt with escaped the awareness of a number of the members.	1.33	0.72
3	64	This board meets socially as a group.	1.21	0.81
1	59	Former members of this board have participated in special events designed to convey to new members the organisation’s history and values.	1.19	0.55

*C1=contextual, C2=educational, C3=interpersonal, C4=analytical, C5=political, C6=strategic

APPENDIX 6 – Board Self Assessment Questionnaire (BSAQ) - responses from non-executive directors (N=37) sorted by highest mean.

C		Question Item	M	SD
3	15	Differences of opinion in board decisions are more often settled by vote than by more discussion.	2.62	0.55
3	52	I am able to speak my mind on key issues without fear that I will be ostracised by some members of this board.	2.59	0.69
4	1	This board takes regular steps to keep itself informed about important trends in the local health economy, and in the wider national healthcare environment, that might affect the organisation.	2.54	0.56
6	40	This board has on occasion evaded responsibility for some important issue facing the organisation.	2.51	0.65
6	16	This board delays action until an issue becomes urgent or critical.	2.49	0.61
1	56	One of the reasons I joined this board was that I believe strongly in the values of this organisation.	2.47	0.62
4	5	Our board explicitly examines the “downside” or possible pitfalls of any important decisions it is about to make.	2.41	0.50
2	26	I have participated in board discussions about the effectiveness of our performance.	2.38	0.72
3	31	The leadership of this board typically goes out of its way to make sure that all members have the same information on important issues.	2.38	0.64
2	38	I have never received feedback on my performance as a member of this board.	2.38	0.79
1	39	It is apparent from the comments of some of our board members that they do not understand the mission of the organisation very well.	2.38	0.68
1	42	There have been occasions where the board itself has acted in ways inconsistent with the organisation’s deepest values.	2.38	0.59
4	53	This board tries to avoid issues that are ambiguous and complicated.	2.38	0.72
6	7	This board is more involved in trying to put out fires than in preparing for the future.	2.36	0.65
4	47	Recommendations from the executive directors are usually accepted with little questioning in board meetings.	2.35	0.48
6	49	Within the past year, this board has reviewed the organisation’s strategies for attaining its long-term goals.	2.32	0.71
2	51	This board has conducted an explicit examination of its roles and responsibilities.	2.32	0.58
4	22	I find it easy to identify the key issues that this board faces.	2.30	0.52
6	8	The board sets clear organisational priorities for the year ahead.	2.28	0.63
6	58	The board discusses events and trends in the larger environment that may present specific opportunities for this organisation.	2.26	0.57
5	48	At times this board has appeared unaware of the impact its decisions will have within our local community.	2.24	0.55
5	25	I have been in board meetings where explicit attention was given to the concerns of the local community.	2.22	0.48
5	54	The executive directors rarely report to the board on the concerns of patients.	2.22	0.71
1	63	This board understands the norms of the professions working in this organisation.	2.20	0.43
4	11	Many of the issues that this board deals with seem to be separate tasks, unrelated to one another.	2.19	0.70
3	27	At our board meetings, there is at least as much dialogue among non executive members as there is between non executive members and executive members.	2.19	0.74
1	50	This board reviews the organisation’s mission at periodic intervals.	2.19	0.66
6	55	I have been in board meetings where the discussion focused on identifying or overcoming the organisation’s weakness.	2.18	0.67
5	9	This board communicates its decisions to all those who are affected by them.	2.16	0.55
1	30	This board has made a key decision that I believe to be inconsistent with the mission of this organisation.	2.12	0.68

C				
*		Question Item	M	SD
6	62	This board makes explicit use of the long range priorities of this organisation in dealing with current issues.	2.09	0.52
3	3	I have had conversations with other members of this board regarding common interests we share outside this organisation	2.08	0.55
2	10	At least once every two years, our board has a retreat or special session to examine our performance, how well we are doing as a board.	2.08	0.86
6	36	At least once a year, this board asks that the chief executive articulate his/her vision for the organisation's future and strategies to realise that vision.	2.08	0.76
5	19	This board has formed ad hoc committees or task forces that include staff as well as board members.	2.01	0.56
1	45	New members are provided with a detailed explanation of this organisation's mission when they join this board.	1.99	0.63
4	61	This board seeks information and advice from leaders of other similar organisations.	1.99	0.67
5	33	The board periodically requests information on the morale of the professional staff.	1.97	0.60
1	13	Values are seldom discussed explicitly at our board meetings.	1.95	0.57
3	20	This board is as attentive to how it reaches conclusions as it is to what is decided.	1.95	0.52
4	28	When issues come before our board, they are seldom framed in a way that enables members to see the connections between the matter at hand and the organisation's overall strategy.	1.92	0.76
6	44	This board often discusses where the organisation should be headed five or more years into the future.	1.89	0.91
2	29	I have participated in discussions with new board members about the roles and responsibilities of a board member.	1.86	0.71
6	35	Our board meetings tend to focus more on current concerns than on preparing for the future.	1.86	0.79
3	57	This board does not recognise special events in the lives of its members.	1.85	0.72
1	12	In discussing key issues, it is not unusual for someone on the board to talk about what this organisation stands for and how that is related to the matter at hand.	1.82	0.69
1	6	Induction programmes for new board members, particularly non executives, specifically include a segment about both the NHS and the organisation's history and traditions.	1.81	0.74
5	14	If our board thinks that an important internal or external stakeholder or stakeholder group is likely to disagree with an action we are considering, we will make sure we learn how they feel before we actually make the decision.	1.81	0.62
2	17	This board periodically sets aside time to learn more about important issues facing NHS Foundation Trusts.	1.81	0.62
2	21	Most people on this board tend to rely on observation and informal discussions to learn about their role and responsibilities.	1.81	0.57
2	34	I have participated in board discussions about what we can learn from a mistake we have made	1.81	0.74
6	65	More than half of this board's time is spent in discussions of issues of importance to the organisation's long-range future.	1.80	0.78
2	46	This board does not allocate organisational funds for the purpose of board education and development.	1.78	0.75
4	4	I have been in board meetings where it seemed that the subtleties of the issues we dealt with escaped the awareness of a number of the members.	1.76	0.68
3	60	This board provides biographical information that helps members get to know one another better.	1.74	0.55
1	37	I have been present in board meetings where discussions of the history and mission of the organisation were key factors in reaching a conclusion on a problem.	1.72	0.61
4	23	When faced with an important issue, the board often "brainstorms" and tries to generate a whole list of creative approaches or solutions to the problem.	1.70	0.78

C				
*		Question Item	M	SD
2	2	I have participated in board discussions about what we should do differently as a result of a mistake the board made.	1.69	0.70
3	32	This board has adopted some explicit goals for itself, distinct from goals it has for the total organisation.	1.68	0.71
5	41	Before reaching a decision on important issues, this board usually requests input from persons likely to be affected by the decision.	1.68	0.67
3	64	This board meets socially as a group.	1.45	0.68
2	24	When a new member joins this board, we make sure that someone serves as a mentor to help this person learn the ropes.	1.42	0.80
3	43	This board relies on the natural emergence of leaders, rather than trying explicitly to cultivate future leaders for the board.	1.39	0.64
2	18	I can recall an occasion when the board acknowledged its responsibility for an ill-advised decision.	1.32	0.63
1	59	Former members of this board have participated in special events designed to convey to new members the organisation's history and values.	1.23	0.63

*C1=contextual, C2=educational, C3=interpersonal, C4=analytical, C5=political, C6=strategic