What the Walker corporate governance recommendations might look like for NHS boards and inspection/regulatory bodies

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Introduction

NHS boards might like to review their corporate governance arrangements in the light of this article, which includes 18 recommendations adapted from the 'Walker Review.'

Given the experience of critical loss and failure throughout the banking system, Sir David Walker was asked by the Prime Minister to review corporate governance in UK banks. His report – ‘The Walker Review’ – was published at the end of November 2009².

In the Press Release associated with his report Sir David said “The fundamental change needed is to make the boardroom a more challenging environment than it has often been in the past……This requires non-executives able to devote sufficient time to the role in order to assess risk and ask tough questions about strategy……..We need to get governance back to centre stage……Improved governance can play an important complementary role by instilling greater confidence in the way banks are being run by their boards and overseen by their owners. This should help regulators to strike the right balance.”

The Walker Review makes 39 recommendations covering the following five key areas:

1. Board size, composition and qualification
2. Functioning of the board and evaluation of performance
3. The role of institutional shareholders: communication and engagement
4. Governance of risk
5. Remuneration

The Review proposes that most of the recommendations are enforced through inclusion in the Combined Code on Corporate Governance. This forms the basis of Monitor’s Code of Governance for NHS foundation trusts and, indeed, forms the basis for much of the corporate governance and related guidance issued to the NHS over the past ten years.

This article looks at key quotations from the review report and suggests what relevant recommendations might look like for NHS boards. The recommendations relating to The role of institutional shareholders: communication and engagement and most of the recommendations relating to Remuneration are not relevant to NHS boards and have, therefore, been excluded. Refer to the report for further information on these aspects.

¹ www.healthcaregovernancereview.org
Notable quotes from the Walker Review report

The following quotes are of particular relevance to NHS board governance and risk.

“…….improvement in corporate governance will require behavioural change in an array of closely related areas in which prescribed standards and processes play a necessary but insufficient part. Board conformity with laid down procedures such as those for enhanced risk oversight will not alone provide better corporate governance overall if the chairman is weak, if the composition and dynamic of the board is inadequate and if there is unsatisfactory or no engagement with major owners. The behavioural changes that may be needed are unlikely to be fostered by regulatory fiat, which in any event risks provoking unintended consequences. Behavioural improvement is more likely to be achieved through clearer identification of best practice and more effective but, in most areas, non-statutory routes to implementation so that boards and their major owners feel “ownership” of good corporate governance.”

“……principal deficiencies in……boards related much more to patterns of behaviour than to organisation. The sequence in board discussion on major issues should be: presentation by the executive, a disciplined process of challenge, decision on the policy or strategy to be adopted and then full empowerment of the executive to implement. The essential “challenge” step in the sequence appears to have been missed in many board situations and needs to be unequivocally clearly recognised and embedded for the future The most critical need is for an environment in which effective challenge of the executive is expected and achieved in the boardroom before decisions are taken on major risk and strategic issues. For this to be achieved will require close attention to board composition to ensure the right mix of both financial industry capability and critical perspective from high-level experience in other major business. It will also require a materially increased time commitment from the NED group on the board overall.”

“……..board-level engagement in risk oversight should be materially increased, with particular attention to the monitoring of risk and discussion leading to decisions on the entity’s risk appetite and tolerance. This calls for a dedicated NED focus on high-level risk issues in addition to and separately from the executive risk committee process and the board and board risk committee should be supported by a CRO with clear enterprise-wide authority and independence, with tenure and remuneration determined by the board.”

What the Walker recommendations might look like for NHS boards and for NHS inspection/regulatory bodies

The recommendations relating to: Board size, composition and qualification; Functioning of the board and evaluation of performance; and Governance of risk are presented here, modified by the author to meet the NHS board governance context. Only one of the recommendations – Recommendation 4 – is directed at NHS inspection and regulatory bodies. Note that the term ‘business’ has been retained and should be interpreted as the business of healthcare.

Board size, composition and qualification

Recommendation 1

To ensure that NEDs have the knowledge and understanding of the business to enable them to contribute effectively, an NHS organisation should provide thematic business awareness sessions on a regular basis and each NED should be provided with a substantive personalised approach to induction, training and development to
be reviewed annually with the chairman. Appropriate provision should be made similarly for executive board members in business areas other than those for which they have direct responsibility.

Recommendation 2

An NHS board should provide for dedicated support for NEDs on any matter relevant to the business on which they require advice separately from or additional to that available in the normal board process.

Recommendation 3

The minimum time commitment of NEDs on an NHS board should be 30 to 36 days per annum and should be clearly indicated in letters of appointment.

Recommendation 4

NHS inspection and regulatory bodies should give closer attention to the overall balance of the board in relation to the risk strategy of the business, taking into account the experience, behavioural and other qualities of individual directors and their access to fully adequate induction and development programmes. Such programmes should be designed to assure a sufficient continuing level of NHS awareness so that NEDs are equipped to engage proactively in NHS board deliberation, above all on risk strategy.

Recommendation 5

The interview process for NEDs proposed for NHS boards should involve questioning and assessment by one or more (retired or otherwise non-conflicted) senior advisers with relevant NHS experience at or close to board level of a similarly large and complex entity.

Functioning of the board and evaluation of performance

Recommendation 6

As part of their role as members of the unitary board of an NHS organisation, NEDs should be ready, able and encouraged to challenge and test proposals on strategy put forward by the executive. They should satisfy themselves that board discussion and decision-taking on risk matters is based on accurate and appropriately comprehensive information and draws, as far as they believe it to be relevant or necessary, on external analysis and input.

Recommendation 7

The chairman of the board of directors of an NHS organisation should be expected to commit a substantial proportion of his or her time, probably around two-thirds, to the business of the entity, with clear understanding from the outset that, in the event of need, the board chairmanship role would have priority over any other business time commitment.
Recommendation 8

The chairman of the board of directors of an NHS organisation should bring a combination of relevant healthcare experience and a track record of successful leadership capability in a significant board position. Where this desirable combination is only incompletely achievable at the selection phase, and provided that there is an adequate balance of relevant healthcare experience among other board members, the board should give particular weight to convincing leadership experience since healthcare experience without established leadership skills in a chairman is unlikely to suffice. An appropriately intensive induction and continuing business awareness programme should be provided for the chairman to ensure that he or she is kept well informed and abreast of significant new developments in healthcare.

Recommendation 9

The chairman is responsible for leadership of the board, ensuring its effectiveness in all aspects of its role and setting its agenda so that fully adequate time is available for substantive discussion on strategic issues. The chairman should facilitate, encourage and expect the informed and critical contribution of the directors in particular in discussion and decision-taking on matters of risk and strategy and should promote effective communication between executive and non-executive directors. The chairman is responsible for ensuring that the directors receive all information that is relevant to discharge of their obligations in accurate, timely and clear form.

Recommendation 10

The chairman of the board of directors should be proposed for election on an annual basis. The board should keep under review the possibility of transitioning to annual election of all board members.

Recommendation 11

The role of the senior independent director (SID) should be to provide a sounding board for the chairman, for the evaluation of the chairman and to serve as a trusted intermediary for the NEDs, when necessary. The SID should be accessible to key stakeholders in the event that communication with the chairman becomes difficult or inappropriate.

Recommendation 12

The board should undertake a formal and rigorous evaluation of its performance, and that of committees of the board, with external facilitation of the process every second or third year. The evaluation statement should either be included as a dedicated section of the chairman’s statement or as a separate section of the annual report, signed by the chairman. Where an external facilitator is used, this should be indicated in the statement, together with their name and a clear indication of any other business relationships with the trust and that the board is satisfied that any potential conflict given such other business relationship has been appropriately managed.

Recommendation 13

The evaluation statement on board performance and governance should confirm that a rigorous evaluation process has been undertaken and describe the process for identifying the skills and experience required to address and challenge adequately
key risks and decisions that confront, or may confront, the board. The statement should provide such meaningful, high-level information as the board considers necessary to assist stakeholders’ understanding of the main features of the process, including an indication of the extent to which issues raised in the course of the evaluation have been addressed. It should also provide an indication of the nature and extent of communication with major stakeholders and confirmation that the board were fully apprised of views indicated by stakeholders in the course of such dialogue.

Governance of risk

Recommendation 23

The board of directors should establish a board risk committee separately from the audit committee. The board risk committee should have responsibility for oversight and advice to the board on the current risk exposures of the entity and future risk strategy, including the embedding and maintenance throughout the entity of a supportive culture in relation to the management of risk alongside established prescriptive rules and procedures. In preparing advice to the board on its overall risk appetite, tolerance and strategy, the board risk committee should ensure that account has been taken of the current and prospective macroeconomic and financial environment.

Recommendation 24

In support of board-level risk governance, an NHS board should be served by a Chief Risk Officer (CRO) who should participate in the risk management and oversight process at the highest level on an enterprise-wide basis and have a status of total independence from individual clinical/business units. Alongside an internal reporting line to the CEO, the CRO should report to the board risk committee, with direct access to the chairman of the committee in the event of need. The tenure and independence of the CRO should be underpinned by a provision that removal from office would require the prior agreement of the board. The remuneration of the CRO should be subject to approval by the chairman or chairman of the board remuneration committee.

Recommendation 25

The board risk committee should be attentive to the potential added value from seeking external input to its work as a means of taking full account of relevant experience elsewhere and in challenging its analysis and assessment.

Recommendation 26

In respect of a proposed strategic transaction involving acquisition or disposal, it should as a matter of good practice be for the board risk committee in advising the board to ensure that a due diligence appraisal of the proposition is undertaken, focussing in particular on risk aspects and implications for the risk appetite and tolerance of the entity, drawing on independent external advice where appropriate and available, before the board takes a decision whether to proceed.

Recommendation 27

The board risk committee (or board) risk report should be included as a separate report within the annual report and accounts. The report should describe thematically the strategy of the entity in a risk management context, including information on the
key risk exposures inherent in the strategy, the associated risk appetite and tolerance and how the actual risk appetite is assessed over time covering both banking and trading book exposures and the effectiveness of the risk management process over such exposures. The report should also provide at least high-level information on the scope and outcome of the stress-testing programme. An indication should be given of the membership of the committee, of the frequency of its meetings, whether external advice was taken and, if so, its source.

**Brief commentary**

- The majority of the 18 recommendations above should present few challenges to well governed NHS boards.
- The new international Standard ISO 31000:2009 *Risk management – Principles and guidance* would help any board ensure adequate arrangements were in place for managing risk.
- **Recommendation 1** calls for appropriate provision of training etc. for executive board members in business areas other than those for which they have direct responsibility. This is a welcome recommendation.
- **Recommendation 3** – the standard time commitment for NHS NEDs is currently 2.5 days per month, or 30 days per year. However, the commitment from some NHS NEDs can be considerably more.
- **Recommendation 4** - NHS inspection and regulatory bodies should give closer attention to the overall balance of the board in relation to the risk strategy of the business, taking into account the experience, behavioural and other qualities of individual directors and their access to fully adequate induction and development programmes. NHS inspection and regulatory bodies currently pay little or no attention to “the experience, behavioural and other qualities of individual directors” and implementation of this recommendation could pose some real challenges for NHS inspection and regulatory bodies. How, for example, do you properly assess the ‘behavioural’ qualities of individual directors?
- **Recommendation 6** recognises the fact that strategy is a management, rather than a governance issue and strategy is developed by the executives for testing by the non executives. However, some NHS boards still believe that they are there to develop strategy, rather than set direction and have strategy developed by the executives.
- **Recommendation 9** could pose challenges in situations where the CEO, rather than the chair, effectively ‘runs’ the board.
- **Recommendation 10**, which calls for board chairmen to be elected on an annual basis, would, perhaps, be challenging in an NHS context.
- Recommendation 12, requiring that the board should undertake a formal and rigorous evaluation of its performance, and that of committees of the board, with external facilitation of the process every second or third year, is a particularly welcome recommendation. There are challenges, however, around agreeing what would constitute a ‘rigorous’ evaluation of board performance.
- **Recommendation 23** – establishment of a ‘board risk committee’. Establishment of such a committee was a key feature of Department of Health guidance issued in 1999 relating to ‘Controls Assurance.’
- **Recommendation 24** – The concept of a ‘Chief Risk Officer’ might be a ‘step too far’ in an NHS context. However, some executive NHS board members do have ‘risk’ or ‘risk management’ in their job title, although this often relates to patient safety risk as opposed to whole organisation (or ‘enterprise’) risk.

SE/HGR/31.12.09