WARD TO BOARD ASSURANCE

CONTEXT

Since the rise in profile of quality in the NHS in the aftermath of Mid Staffs and other significant failures e.g. Morecambe Bay, there has been a constant and niggling doubt about the connectivity of trust boards to actual service delivery - the so called Ward to Board connection. The 'disconnect' of trust boards from the reality of day to day operational delivery has often been quoted as one of the key reasons for the failure to address long term inadequate performance.

The consensus of those working in the NHS recognises the importance of 'getting out of the boardroom' or 'bringing the ward into the boardroom'. However, the complexity of trust boards fully understanding what is happening in each and every ward/department within their organisation is not without its challenges including:

- Availability of NEDs who in theory are contracted for two or three days per month.

- Sheer number of wards/departments coupled with the multifarious activities that they deliver.

- A single coherent set of indicators covering all areas is often too high level and generic in nature to provide the necessary level of assurance required to satisfy expectations of the public, staff, media and regulators.

Despite these difficulties, it is vital that board members make better connections within their organisations to enable them to triangulate the messages contained in board papers with observations and interactions with patients, staff and stakeholders. This paper seeks to set out some of the key issues often encountered in trying to develop effective ward to board assurance arrangements and also highlights areas of good practice and some helpful tips gleaned from both our experiences and the experiences of our members.

ISSUES

There are a number of challenges in developing an effective ward to board assurance flow:

- The myriad of clinical and/or quality related forums that typically exist even in the smallest trusts between an individual ward and the board. We have experienced up to 45 clinical 'sub-committees' covering issues such as medical devices, medications, NICE guidance, mortality, safeguarding, infection control and single issue groups including pressure ulcers and falls.

- Subcommittee structures that cut across the requirement for a holistic approach to integrated reporting and assurance as functional groups tend to create a fractured and individually narrow approach to governance.

- Forums are often set up in response to statutory requirements or as a means of creating positions of responsibility for key personnel however these committees often remain long after the rational for their existence has ceased to be relevant.

- There is even greater potential for these issues to develop in academic teaching status organisations and those with multiple site operations.

- A failure to separate performance management and assurance with the two often being conflated via poor organisational structure design. In essence what we have seen and heard is that many trusts' quality committees, which should essentially be focused on providing the board with evidence of assurance, appear to have a role in holding the organisation to account for the delivery of the operational quality agenda. This can lead to confusion and fractured performance management arrangements with finance and operational targets being discussed in executive led performance meetings and quality targets being discussed in board committees. The role of a quality committee is to provide the Board with evidence of assurance over all aspects of quality of clinical care; clinical governance systems and clinical risks.

- Inconsistency in the management of divisions/directorates, often with little or no centrally prescribed accountability framework. This means that frequently there is no standard reporting template, common currency or language, or approach which makes the task of implementing a coherent set of metrics, appropriately stratified at each level which cogently builds up through the organisation through to the board, extremely challenging.

The above issues, coupled with board members who have limited visibility, outside of the board room, across the full spectrum of services, departments and/or sites can lead to significant gaps in assurance from the ward to the board.

SOLUTIONS

Whilst we recognise that each organisation is unique, operating within its own environment with its own challenges, as ever there are commonalities that cut across providers and this is no different in terms of some of the more practical steps in creating assurance from ward to board.
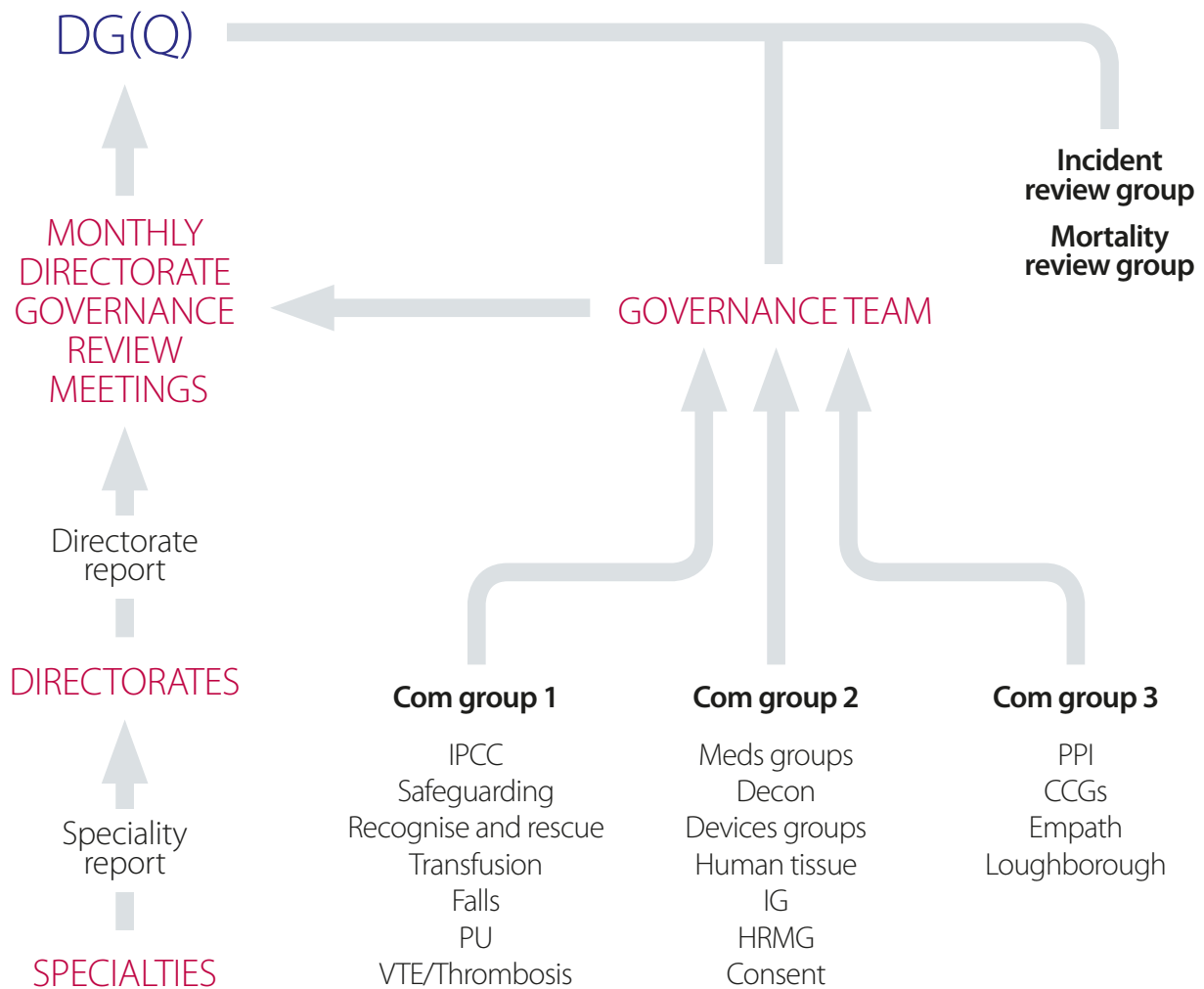
We list below some of the more practical solutions and good practice examples expressed to us, mentioned in articles or experienced when undertaking reviews of governance arrangements:

- Clarity of roles and responsibilities of each individual forum – in effect an assurance map of the organisation which seeks to make sense of the 'spaghetti' lines of communications often found in organisations by pictorialising the governance infrastructure in an organogram alongside the key assurance flows.

- Clear separation of operational management and assurance via dedicated 'spines' running through the organisation.

- Good governance practice that include post meeting wash up time that identifies key outcomes from the meeting for reporting up/down/sideways through the organisation alongside new risks or actions. Most organisations now include some process for escalating concerns to the board but providing feedback from the board to the committee and onward down through the organisation is less common.

- A board level programme of engagement activities that takes all directors out of the boardroom to assist with triangulation of assurance beyond written board papers. Activities should be designed and planned to maximise exposure and prioritise visits based on a risk profile whilst also ensuring that perceived low risk areas and areas of exemplary practice are not overlooked. Such activities should incorporate patient safety style walkabouts, 15 Steps, Listening Into Action, staff/patient forums or group gatherings and celebration of good practice events.

- Ensure ward data is presented to the board in a format that aids triangulation and allows the board to spot early warning signs rather than discrete

packages that in themselves do not trigger concerns Use of additional in depth triangulation events for executive clinical leaders such as back to the floor days, experience days and shadowing.

- Clear alignment and monitoring of organisational objectives from board down through the divisions/directorates to individual's objectives (often value based) via robust and consistent business planning, performance management processes and individual appraisals. This is often difficult to achieve in practice but perseverance over a period of time leads to success.

- Clear and defined feedback loops re issues identification, action planning and resolution followed by post implementation audits i.e. did the actions identified have the desired effect?

- Use of board workshops to engage with divisions/ directorates on a cyclical basis focusing on current and future challenges, developments, innovations, risks and opportunities. The purpose of these events is to share information and build knowledge as opposed to operational problem solving which is not the remit of board workshops.

- Review, refresh and simplify the sub-committee structure that supports quality – consider amalgamation of single interest groups and upwards reporting and accountability arrangements to ensure that each forum has appropriate feed in and feed out lines of communications. Equally the standing and reporting lines of these sub-committees should be such that they can inform and influence operational behaviour.

- Ensure that divisions/directorates are placed at the centre of quality governance in the organisation and are bought into the key elements of the process. Helpful ways in which this can be achieved is to set out clear organisational expectations re meetings, agendas, report templates, membership, frequency etc. and to ensure that the quality governance structure places divisions/directorates central to the assurance process.

See over for an example structure.

DG(Q)

MONTHLY
DIRECTORATE
GOVERNANCE
REVIEW
MEETINGS

GOVERNANCE TEAM

**Incident
review group**

**Mortality
review group**

Directorate
report

DIRECTORATES

Speciality
report

SPECIALTIES

Com group 1

IPCC
Safeguarding
Recognise and rescue
Transfusion
Falls
PU
VTE/Thrombosis

Com group 2

Meds groups
Decon
Devices groups
Human tissue
IG
HRMG
Consent

Com group 3

PPI
CCGs
Empath
Loughborough

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