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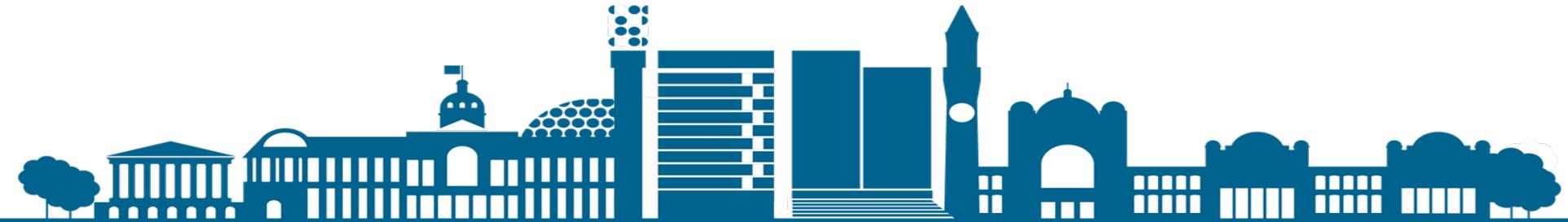
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Well-led for quality

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Acknowledgement

This represents the work and thinking of a team:

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Agenda

- Boards, leadership and care quality
- The long shadow of Francis
- What does the research literature tell us?
- Findings from new empirical research in the NHS
- What this means for NHS boards





“What if we don’t change at all ...
and something magical just happens?”

Boards, leadership and care quality

- Policy assumes that boards can and should lead for quality, and that they can bring about important change
- The Monitor well-led domains, used by CQC:
 - Strategy and planning
 - Capability and culture
 - Process and structures
 - Measurement
- But how does this play out in practice and what insights does research evidence offer?



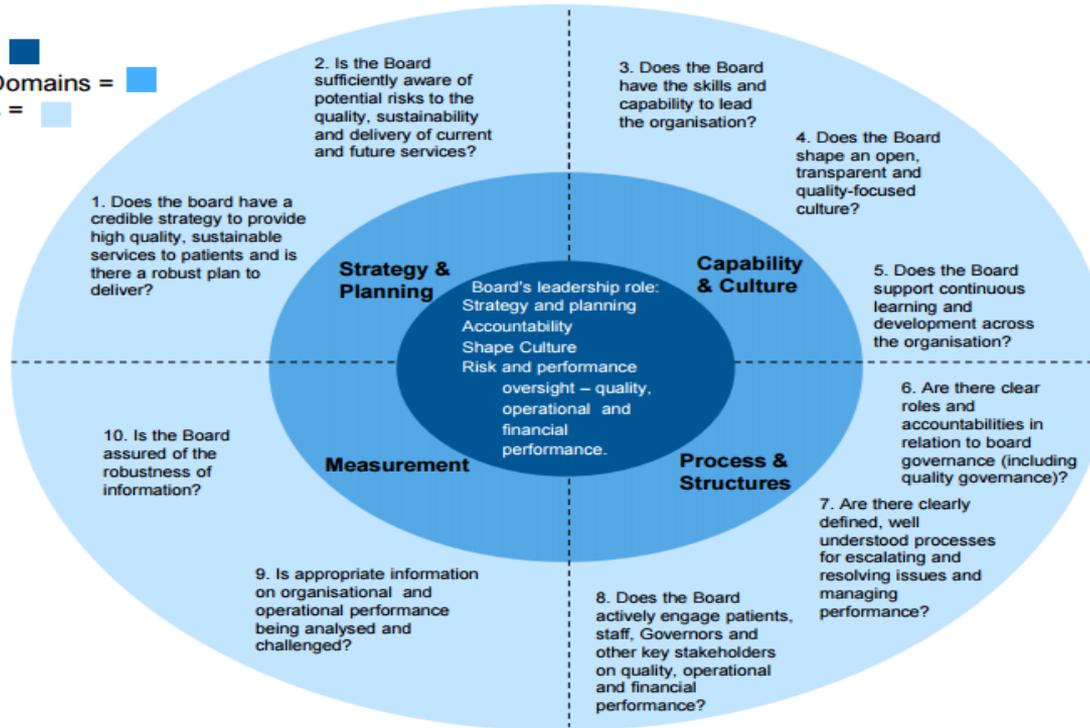
Combining our approach to board and quality governance leads to a Well Led Framework

Key:

Board's role = ■

Governance Domains = ■

Key questions = ■



The long shadow of Francis

‘What brought about this awful state of affairs? **The Trust Board was weak.** It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust’s attention.

‘It did not tackle the tolerance of poor standards and the disengagement of senior clinical staff from managerial and leadership responsibilities.

These failures were in part due to a focus on reaching targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care.’

Sir Robert Francis QC, 6 February 2013



What does the research literature tell us?

Boards and high performing hospitals (Chambers et al, 2013):

- More time is spent on clinical quality in board meetings (and more than is spent on financial performance)
- Quality is a higher priority for CEO performance evaluation
- An effective quality committee is in place
- Sufficient and committed clinical membership of the board
- Greater expertise and formal training in quality for board members
- Boards are more familiar with current performance and very involved in reviewing quality data



Towards a framework for enhancing the performance of NHS boards: a synthesis of the evidence about board governance, board effectiveness and board development

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What does the research literature tell us?

Boards and oversight of patient safety (Mannion et al, 2016):

- Boards that prioritise quality and safety are more likely to run high performing organisations
- Key factors include: time spent on quality issues; focus on benchmarking; quality committee with clinical membership; involving medical staff in development of quality strategy
- Critical to ensure technical competence and proficiency of board members in measuring quality and safety
- Nursing leadership often too low profile
- Important that staff feel safe to raise concerns, and confident these will be addressed, for safer higher quality care





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Do Hospital Boards matter for better, safer, patient care?



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ABSTRACT

Manifest failings in healthcare quality and safety in many countries have focused attention on the role of hospital Boards. While a growing literature has drawn attention to the potential impacts of Board composition and Board processes, little work has yet been carried out to examine the influence of Board competencies. In this work, we first validate the structure of an established 'Board competencies' self-assessment instrument in the English NHS (the Board Self-Assessment Questionnaire, or BSAQ). This tool is then used to explore in English acute hospitals the relationships between (a) Board competencies and staff perceptions about how well their organisation deals with quality and safety issues; and (b) Board competencies and a raft of patient safety and quality measures at organisation level.

National survey data from 95 hospitals (334 Board members) confirmed the factor structure of the BSAQ, validating it for use in the English NHS. Moreover, better Board competencies were correlated in consistent ways with beneficial staff attitudes to the reporting and handling of quality and safety issues (using routinely collected data from the NHS National Staff Survey). However, relationships between Board competencies and aggregate outcomes for a variety of quality and safety measures showed largely inconsistent and non-significant relationships.

Overall, these data suggest that Boards may be able to impact on important staff perceptions. Further work is required to unpack the impact of Board attributes on organisational aggregate outcomes.

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What does the research literature tell us?

Board composition (Chambers et al, 2013 and forthcoming):

- Stability of board membership and longevity of CEO are important for effective governance of patient safety
- Having doctors on the board is associated with higher ratings of care quality, patient experience and also finance
- Expertise and training in quality of care is significant in relation to high performing organisations
- Triadic approach of high challenge, trust and engagement vital
- Lack of gender and ethnic diversity of board membership matters, and increasingly so (Kline, 2014; West et al, 2015)



I SEE THE CHAIRMAN
HAS IMPLEMENTED
THE DIVERSITY PROGRAMME



What does the research literature tell us?

Boards and creating positive organisational culture

(Dixon-Woods et al, 2013):

- Keep reinforcing an inspiring organisational vision
- Promote staff health and wellbeing
- Listen to, and involve, staff at all levels
- Provide staff with helpful feedback and celebrate achievements
- Take effective, supportive action to tackle problems
- Ensure staff feel safe, valued and respected
- Develop and model excellent teamwork as a board



Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study

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ABSTRACT

Background Problems of quality and safety persist in health systems worldwide. We conducted a large research programme to examine culture and behaviour in the English National Health Service (NHS).

Methods Mixed-methods study involving collection and triangulation of data from multiple sources, including interviews, surveys, ethnographic case studies, board minutes and publicly available datasets. We narratively synthesised data across the studies to produce a holistic picture and in this paper present a high-level summary.

Results We found an almost universal desire to provide the best quality of care. We identified many ‘bright spots’ of excellent caring and practice and high-quality innovation across the NHS, but also considerable inconsistency. Consistent achievement of high-quality care was challenged by unclear goals, overlapping priorities that distracted attention, and compliance-oriented bureaucratised management. The institutional and regulatory environment was populated by multiple external bodies serving different but overlapping functions. Some organisations found it difficult to obtain valid insights into the quality of the care they provided. Poor organisational and information systems sometimes left staff struggling to deliver care effectively and

high-quality care. Organisations need to put the patient at the centre of all they do, get smart intelligence, focus on improving organisational systems, and nurture caring cultures by ensuring that staff feel valued, respected, engaged and supported.

INTRODUCTION

A commitment to delivering high-quality, safe healthcare has been a policy goal of governments worldwide for more than a decade, but progress in delivering on these aspirations has been modest:¹ patients everywhere continue to suffer avoidable harm and substandard care.^{2–3} England’s National Health Service (NHS) has not been immune to these problems. Despite some encouraging evidence of improvement in quality and safety,^{4–5} large and inexplicable variations in quality of care are evident across multiple domains and sectors of healthcare, from primary through to community and secondary care.^{6–7} England has also seen a number of high-profile scandals involving egregious failings in the quality and safety of individual providers. These include the case of Mid Staffordshire NHS Foundation Trust,⁸ the subject of a recently published public inquiry by Sir Robert Francis into how catastrophic fail-

What does the research literature tell us?

Boards and quality improvement (Fulop et al, 2016):

- Quality improvement 'maturity' is linked to patient and staff engagement, using data for improvement, clinical leadership, sustained QI focus
- There seems to be a relationship between QI maturity and trust performance
- But it is not clear which factor affects which
- Some boards are managing to really shift from quality assurance to quality improvement
- Data for QI is critical, as is staff, patient and clinical engagement





QUASER

Quality and Safety in European Union Hospitals

Quality and Safety in European Union Hospitals A Research-based Guide for Implementing Best Practice and a Framework for Assessing Performance (QUASER)

Funded by the EU Seventh Framework Programme (FP7). April 2010 - June 2013.

Contact: [Prof Naomi Fulop](#)

This three-year study explored the relationships between the organisational and cultural characteristics of hospitals, and how these impacted upon clinical effectiveness, patient safety and patient experience in European Union countries. Co-ordinated by the Department of Applied Health Research, UCL, partners included the Imperial Centre for Patient Safety and Service Quality (CPSSQ); the Department of Health Studies at the University of Stavanger, Norway; the Department of Health Policy & Management, Erasmus University, Netherlands; Kultorum, Jönköping County Council, Sweden; ISCTE – Instituto Universitário de Lisboa, Lisbon, Portugal; King's College London, UK.

The key objectives of the project were to identify organisational and cultural characteristics linked to the effectiveness, safety and patient experience of hospital care, and the quantitative and qualitative indicators of this. Data was collected in 10 hospitals in the five partner countries (two in each of the five partner countries), with additional studies of two clinical microsystems in five of these (one in each of the partner countries).

Whilst there is a good understanding of the types of quality improvement undertaken in healthcare, less is known of the organisational and cultural processes that determine the effectiveness of these methods. By examining the relationship between these processes and quality from macro (national healthcare system) down through the meso (hospital) to micro (frontline clinical team) levels in each of the five partner countries, the study revealed how the dynamics and interactions between these different levels impacted on sustained quality of hospital care.

Based on the findings from this research, and in consultation with a stakeholder group comprising senior hospital leaders, payers and patient representatives from across Europe, the project team have produced two research-based Guides. The first is for senior hospital leadership teams to identify the strengths and possible weaknesses in their organisation's quality and safety improvement efforts, and what they may need to do to improve. The Guide provides some suggested strategies for a hospital could be organised better in order to deliver high quality and safe services. It then provides examples from hospitals that have

The QUASER Guides

- > [The Hospital Guide](#)
- > [The Guide for Payers](#)

Newsletters

- > [QUASER Spring/Summer 2013 newsletter](#)
- > [QUASER Winter 2012 newsletter](#)
- > [QUASER Summer 2012 newsletter](#)
- > [QUASER Autumn 2011 newsletter](#)
- > [QUASER Spring 2011 newsletter](#)

Project Documents

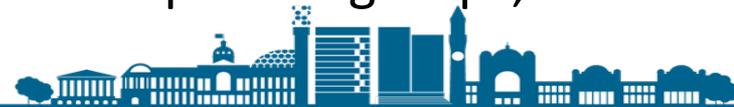
- > [QUASER project summary](#)
- > [QUASER leaflet](#)
- > [QUASER conference poster](#)

Links

- > [Deepening our understanding of quality improvement in Europe \(DUQuE\)](#)
- > [European Union Network for Patient Safety and Quality of Care, PaSQ](#)
- > [European Health Management Association \(EHMA\)](#)
- > [European Hospital and Healthcare Federation \(HOPE\)](#)

Findings from new empirical research

- Department of Health Policy Research Programme funded study of the leadership changes made by boards following the Francis Inquiry
- Led by Professor Naomi Chambers at University of Manchester, with University of Birmingham and Nuffield Trust
- Literature review
- Interviews with national policy makers
- National survey of board members (n=385)
- Six in-depth case study hospital trusts – interviews, surveys of ward and dept managers, focus groups with staff and patient groups, board observations



1. Change in boards' focus on quality

- More time and attention being given to quality and safety at board meetings
- Greater investment in nurse staffing levels post-Francis
- Patient safety deemed more important than long-term financial sustainability, despite tensions
- Workforce pressures increasingly significant

'The Francis Report helped the trust board to make decisions that are in the best interests of patients, regardless of the financial outcome. Whilst this sounds simplistic, it ensured that in a climate of staff shortages, we were prepared to pay what was necessary to ensure safe rotas.'



2. Post-Francis changes led by boards

- Greater focus on complaints handling, better reporting and learning from serious incidents
- Improved governance arrangements, albeit from very different baselines
- Widespread efforts by boards to promote certain cultures and values throughout the organisation
- Duty of Candour considered useful and generally embraced
- Big effort to improve staff engagement
- ‘Speaking up’ arrangements more heavily emphasised in some organisations than others



3. Enablers of post-Francis changes led by boards

- Having a strong and effective human resource and organisational development function
- In-house programmes to improve governance, quality and safety, complaints handling etc.
- Sustainability and transformation plan-related work that was improving local system relations
- A board that is able to sustain (in the eyes of staff) reliable, consistent and clear messaging
- A body of governors and patient representatives who are engaged closely in trust quality and safety work
- Using complaints and incidents as part of a wider programme of trust learning and review

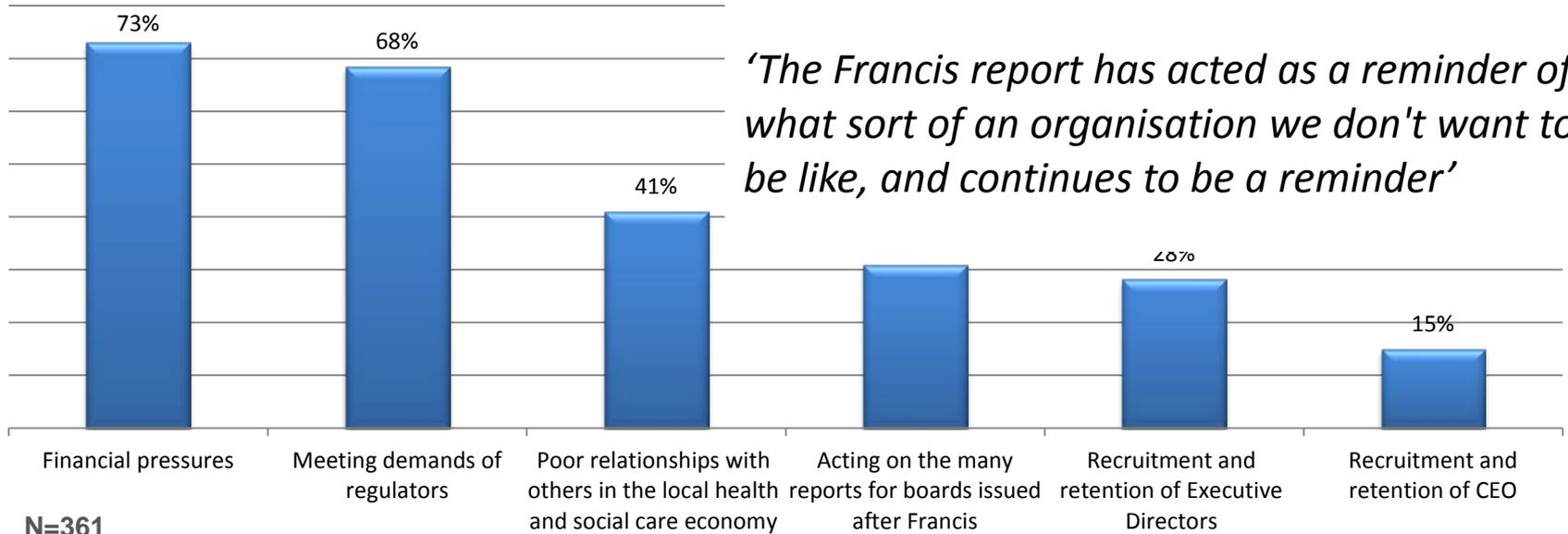


4. Barriers to post-Francis changes led by boards

- Financial, performance & workforce pressures
- Variable involvement of patients and staff in service improvement
- Mixed quality of middle management and the impact this has on the operation of governance, effective team-working and communications
- Perceived poor commissioning, and lack of engagement of providers in planning for change
- ‘Regulatory throttle’: too many DH reports, lack of consistency between NHSE and NHSI, CQC (seen by some) as a blunt instrument



Which of the following has your board experienced as significant barriers to improving its leadership?



5. Board roles and behaviours following Francis

- Francis caused pause for thought, and legitimation of direction of travel in relation quality and safety
- Boards & individual members have led efforts to promote values and culture
- Premium placed by staff on visibility of board members
- Chief nurse role has become more high profile: *‘pricking the conscience of the board’*
- The space created for strategic thinking by boards varies
- More stable boards are more unitary in how they work
- Engaged, challenging as well as supportive non executive directors are critical (the triad)
- Only one case study board demonstrated excellence in equality and diversity



What this means for NHS boards

- Francis has had an important impact on board priorities and culture despite protestations that ‘we were doing this anyway’
- Growing financial, workforce and performance pressures now threaten the pursuit of the quality agenda
- Regulation can be experienced more as a ‘throttle’ and pressure, than as a support of quality and safety
- How to manage and maximise the value of multiple regulators is a key challenge for boards and executive teams
- Patient and staff engagement are a powerful lever for boards seeking to hold the quality and safety line



What this means for NHS boards (2)

- This latest research evidence points to the need for a 'restless board' that seeks constantly to find out more, benchmark itself, do better, check on prior concerns and actions
- The board also needs to provide stability and consistency of purpose in a turbulent and pressured NHS
- Board members need to embrace the full repertoire of board purposes and mechanisms identified in prior research
- Time for board training in quality and safety matters (including use of data) is vital
- Clinical roles and input matter – and nursing increasingly so
- Time for board development and reflection



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