

Effective board governance of safe care: a (theoretically underpinned) cross-sectioned examination of the breadth and depth of relationships through national quantitative surveys and in-depth qualitative case studies

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Plain English summary

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Health-care scandals, such as the most recent at Mid Staffordshire NHS Foundation Trust, have demonstrated that uncaring practices can flourish in hospitals when the organisational context goes wrong. When this happens, patients not only have unpleasant experiences during care but can be hurt or even die as a consequence. Hospital boards have ultimate responsibility for safeguarding the care provided in their organisation, yet recent high-profile reports on serious failings in the quality of hospital care in the NHS have raised concerns over the ability of boards to discharge their duties effectively in this area. This research seeks to better understand the processes associated with the effective board governance of safe care. Based on a review of the available evidence and research in hospitals we examine in detail what hospital boards actually do in relation to safeguarding care in their organisation; for example, how much time they spend discussing patient safety issues, the types of information boards use to assess the quality of care in their organisation, what training and skills board members have in relation to patient safety and how factors, such as external financial incentives, influence what boards do in relation to patient safety. We found that what boards do and focus on is related to how their hospital reacts to and deals with patient safety issues. In particular, we found a link between self-assessed competencies of boards and whether or not its staff felt able to openly report patient safety-related problems and incidents.

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