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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Scientific summary

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Background

Hospital trust boards in the NHS have statutory responsibility for upholding quality and safety of care in its organisation. However, recent high-profile reports into serious failings in the NHS, most notably the standards of care at Mid Staffordshire NHS Foundation Trust, raise concerns over the ability of trust board to discharge these duties effectively. Despite a plethora of guidance available to NHS boards on effective governance, significant gaps remain in our understanding of what board governance looks like and the organisational processes through which safer care is accomplished and sustained. Prior to this study, most of the research on hospital board governance originated from the USA, was theoretically underdeveloped, focused on the more generic concept of service quality rather than on patient safety and was almost entirely of a quantitative nature. Against this background we wanted to strengthen the theoretical and empirical evidence base that underpins board governance of safe care in the NHS.

Objectives

Our study aimed to generate theoretically grounded empirical evidence on the associations between board practices, patient safety processes and patient-centred outcomes.

The specific aims were:

1. to identify the types of governance activities undertaken by hospital trust boards in the English NHS with regard to ensuring safe care in its organisation
2. in foundation trusts, to explore the role of boards and boards of governors with regard to the oversight of patient safety in its organisation
3. to assess the association between particular hospital trust board oversight activities and patient safety processes and clinical outcomes
4. to identify the facilitators and barriers to developing effective hospital trust board governance of safe care
5. to assess the impact of external commissioning arrangements and incentives on hospital trust board oversight of patient safety
6. on the basis of findings relating to points 1–5, to make evidence-informed recommendations for effective hospital trust board oversight and accountability and board member recruitment, induction, training and support.

Methods

The study comprised three distinct but interlocking strands:

1. A narrative systematic review in order to describe, interpret and synthesise key findings and debates concerning board oversight of patient safety. In selecting papers, we focused on those that considered board oversight in the context of quality and safety, and the research team and expert panel suggested seminal works and advised on search terms. The team then reviewed titles and abstracts for relevance, using broad inclusion criteria to identify studies of hospital board directors' or boards of trustees' oversight of quality and patient safety. Our initial search uncovered 187 articles and after review we identified a subset of 66 papers for detailed study, which we added to those identified by earlier reviews, removing duplicates. Finally, we used snowballing techniques to augment papers for review.

These searches were adapted iteratively to ensure maximum capture of empirical work, and at the end of the process 124 publications were deemed relevant for detailed review.

2. In-depth, mixed-methods case studies in four organisations were used to assess the impact of hospital board governance and external incentives on patient safety processes and outcomes. We used background statistical data on quality/safety indicators to select case study sites that were indicated as getting worse (in the light of overall improvement of other hospitals) or getting better, and comprising two foundation hospital trusts with a 'downwards' performance trajectory, and two foundation hospital trusts with an 'upwards' performance trajectory. We then made sure that the sample was drawn from across the country and included large teaching hospitals and a district general hospital. We carried out semistructured interviews with the board of directors at each site. In addition to these interviews, the research team undertook overt non-participant observation at four management board meetings at each case study site. This totalled nearly 50 hours of observation. Descriptive free-text field notes were taken by both observers at each meeting, supplemented with documentary data, including the agenda, supporting papers and (retrospectively on completion) the minutes of each meeting. Data included an overview of comments made, questions raised and by whom and a log of the time spent on each agenda item. We supplemented our analysis of board 'conformance' and board 'performance' activities with further analysis of observation field notes.
3. Two national surveys were undertaken about board management in NHS acute and specialist hospital trusts in England. The first of these surveys was issued to 150 trusts in the financial year 2011/12 as part of the annual trust survey carried out by Dr Foster (Dr Foster Limited, London, UK). The questionnaire was completed online via a dedicated web tool. This survey gathered data on each trust's board and activities related to the oversight of patient safety; 145 replies were received, making for an overall response rate of 97% (unusually high, we suspect, because of high levels of engagement with Dr Foster). The second survey targeted individual board members from these trusts. We used an adapted version of the Board Self-Assessment Questionnaire (BSAQ). This survey was also completed through online means and data were gathered between May 2012 and April 2013. A total of 334 responses were received from 165 executive and 169 non-executive board members, providing at least one response from 95 of the 144 (66%) NHS trusts in existence at that time. After constructing the factor scores representing the six BSAQ dimensions and the total BSAQ score, we explored whether or not these were correlated with patient safety measures. In doing so, we estimated various multivariate models regressing patient safety measures (from Dr Foster) and measures of hospital ability to handle errors, near-misses and incidents, taken from the National NHS Staff Survey (NSS) for 2012 on the total BSAQ score, controlling for a number of hospital-level characteristics.

Results

This section takes each of the research objectives in turn and integrates findings from across all parts of the study.

Research objective 1: to identify the types of governance activities undertaken by hospital trust boards in the English NHS with regard to ensuring safe care in its organisation

In the national survey a very high proportion of trust boards reported the kinds of desirable characteristics and board-related processes that research says may be associated with higher performance, with all having quality subcommittees and proactive procedures in place to address patient safety concerns, and almost all having explicit objectives related to improving patient safety. However, only 87% of trusts reported that board members had actually received any received training in patient safety issues. Our analysis of the symbolic aspects of board activities highlights the role and differences in local processes of organising in relation to the governance of patient safety. Although each case study identified different approaches in different situations, it was clear that the setting(s) in which board decisions and deliberation take place have an important bearing on how organisations approach the oversight of patient safety.

We also found that most boards do allocate a considerable amount of time to discussing patient safety- and quality-related issues. The responses obtained by the NSS indicate that only one-fifth of trust boards reported that ≤ 30% of its time was spent discussing safety and quality issues. In the case studies we found similar evidence, with only one study site allocating < 30% of its board time to debating quality/safety matters. However, we also identified (through the case study sites) that boards used this time rather differently.

In the national survey we found that hospital boards were using a wide range of hard performance metrics and soft intelligence to monitor its organisations with regard to patient safety, including a range of clinical outcomes measures, infection rates and process measures, such as medication errors and readmission rates. Softer intelligence, used organisationally and reported at all board meetings, was also more variably reported, with discussions with clinicians and executive walkabouts being most often reported, alongside use of patient stories. However, in only about two-thirds of trusts did board members shadow clinicians and report back to the board.

Research objective 2: to explore the role of boards versus boards of governors in foundation trusts with regard to the oversight of patient safety in its organisation

A strong theme from across study sites was that, although the boards of governors are generally perceived as well meaning, they were also considered to be largely ineffective in helping to promote and deliver safer care for its organisations. Boards of governors seemed to serve a useful educative role and community linkage role, but with limited challenge or holding of executives to account. Meetings frequently resembled seminars for information sharing, rather than a formal board meeting where key organisational strategies were debated and discussed. Thus, while governors typically reported good relations with the executive board, there was often a lack of awareness and understanding of respective roles. Although some sites did report engagement of governors in quality assurance work in relation to, for example, non-executive director (NED) appraisal and committee work, there were also frustrations at what was seen as only limited active engagement from NEDs.

Research objective 3: to assess the association between particular hospital trust board oversight activities and patient safety processes and clinical outcomes

The headline finding here is that we did not find any statistically significant relationship between board attributes and (self-reported) processes and any patient safety outcome measures. However, we did find a significant relationship between two dimensions of the BSAQ and two specific-and-related NSS organisational 'process' measures: (1) staff 'feeling safe' to raise concerns about errors, near-misses and incidents and (2) staff 'feeling confident' that their organisation would address their concerns if raised. In particular, the correlational results are positive and significant for staff 'feeling safe' in the contextual, analytical, political and strategic domains of the BSAQ, although the effect is strongest in the contextual dimension. This contextual dimension explores how the board takes cognisance of the organisation's values and norms, and positive orientations here may support a more open and transparent culture around whistleblowing, thus enabling staff to feel safe to raise quality concerns. Results were also positive and significant for staff 'feeling confident' for the contextual and strategic BSAQ dimensions, suggesting that a focus on the organisational values and institutional direction gives staff a sense of security and assurance that patient safety concerns will be dealt with. These findings then do suggest some association between board governance and staff ability to address issues around patient safety, but we found no evidence to support the view that board governance directly affected patient safety outcomes. The finding linking board orientations to staff attitudes from our large-scale quantitative work are further substantiated by the qualitative findings, especially those that were gleaned from the following of 'tracer conditions' from board to ward.

Research objective 4: to identify the facilitators and barriers to developing effective hospital trust board governance of safe care

In the case studies we explored these dimensions and identified a range of facilitators and enablers to effective board governance of safe care. For example, a key facilitator at one of our study sites appeared to have been the development and implementation of a clear corporate strategy and operational plan focused on enhancing the quality and safety of care in the organisation. At other sites, the stability of board membership over time was considered to be an important facilitator of patient safety governance, and the detailed knowledge of, and connection with, clinical staff by the CEO was also thought to be crucial. Strong and committed clinical leadership was also considered to be an important facilitating factor in supporting board governance, even when there were persistent concerns over the so-called bullying of junior professionals by senior clinicians. We identified a range of other organisational barriers to effective board governance of safe care across the case study sites. Problems and disputes over the validity and reliability of summary performance indicator data, and apparent difficulties in communication between clinical units and the board, for example, led to a sense of confusion over the meaning and the correct interpretation of performance indicator data received and reviewed by the board. In addition, problems were seen to arise because of a perceived lack of engagement among senior medical staff, resulting in impaired communication between corporate teams and ward level in many parts of the organisation.

Research objective 5: to assess the impact of external commissioning arrangements and incentives on hospital trust board oversight of patient safety

Across the case studies we found that contracting issues appeared to play only a relatively minor role in incentivising quality and safety improvement. Building strong and trustworthy relationships between commissioners and providers was often viewed as a better way of stimulating positive change, rather than focusing on incentives and sanctions. Commissioning for Quality and Innovation (CQUIN) appears to have had a mixed impact across the case study sites and were generally perceived to be a low-powered incentive for quality and safety improvement, as well as possibly inducing a range of unintended and dysfunctional consequences.

Concluding remarks

There remains a challenging governance- and management-focused research agenda around safer care. Specific methodological issues and substantive areas that warrant further and more sustained investigation might be considered in the following areas:

1. Our finding that board governance/competencies appear to be linked to staff feeling safe to raise concerns about patient safety issues, and also their confidence that their organisation would address their concerns, is worthy of further and more sustained exploration, particularly in the context of the current focus on improving whistleblowing policies in the NHS.
2. It would be useful to undertake empirical research to explore the scope, range and impact of systematic group decision-making bias in board settings on patient safety processes and outcomes.
3. There is a real need for more and better-tested bespoke instruments and tools for assessing and informing hospital board governance and competencies.
4. A challenge lies in understanding how different levels of organisational hierarchy articulate together. Understanding how the dialogue and discourse creation at one level informs and influences the cultures and practices at another is key, as is identifying and elucidating the key conduits through which the governance of safety plays out.

In summary, this is the first large-scale mixed-methods study of hospital board activity and behaviour related to the oversight of patient safety in the English NHS. As such, we believe that it has much to contribute to an understanding of boards, its influence and its operation.

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