

PUTTING QUALITY FIRST IN THE BOARDROOM

Improving the business of caring

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 **Burdett Trust**
for Nursing

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Foreword

The quality of clinical care *is* the business of NHS organisations – a self-evident truth that has been undermined by recent failings at Maidstone and Mid Staffordshire, for example. This report presents evidence on how organisations and individuals at board level approach their responsibilities and accountability for the core business of patient care. The resulting pointers for the boards of NHS organisations and their nurse executives are thus rooted in, and resonate with, reality.

Five years ago, the Burdett Trust for Nursing started out on a journey to address the gap between the reality of patient care and what appeared to be the main focus of NHS boards. The nurse executive – a role that varies widely in scope, authority and perception – was seen as the lynchpin. *Who Cares, Wins*, the first report commissioned by the Burdett Trust, made clear observations and recommendations that we were determined would not gather dust on a shelf. Our partnership with The King's Fund has resulted in wide uptake of, and discussion about, board-level engagement in the quality of clinical care and the added value that nurse executives can bring.

The Burdett Trust for Nursing, together with The King's Fund team, is proud to be making a contribution to the fast-rising clinical quality agenda. We do not expect to stop here and will continue the journey to ensure that the quality of care is at the heart of NHS organisations.

We would like to thank our fellow trustees for their support, and we would like to express our particular thanks to Sue Machell and her team for their excellence and enthusiasm.

Ray Greenwood

Sue Norman

Trustees, Burdett Trust for Nursing

Preface

This report is part of a programme of work undertaken by The King's Fund to better understand how NHS boards assure themselves about the quality of clinical care that patients receive, and how nurse executives can help them with this vital task. In essence, the aim of the programme is to support nurse executives and NHS trust boards to 'bring the ward to the board'. The programme has been undertaken in partnership with the Burdett Trust for Nursing, a charity that offers grants to support the nursing contribution to health care.

The programme builds on the results of two pieces of work commissioned by the Burdett Trust and carried out by the Office for Public Management (OPM 2006) and the University of Plymouth (2006), which examined the ability of trust boards to focus on the 'business of caring' and the role of nurse executives in supporting this. It addresses longstanding concerns about the lack of attention NHS boards have given to the quality of clinical care in comparison with financial and operational performance.

Executive clinicians should play a prominent role in bringing issues of quality into the boardroom. Our focus is on nurse executives; as leaders of the largest part of the workforce with involvement in all components of clinical quality and governance, they have considerable power to influence the patient experience. It is their breadth of focus (most nurse executives have extremely diverse portfolios – see OPM 2006 for further commentary around this, and page 21 of this report), combined with accountability for the quality of nursing, that makes the nurse executive role both so distinct and so invaluable. The nurse executive has the potential to bring to the board an unparalleled understanding of the nurse's role and the standard of clinical care that is being provided by the trust.

Yet even the most skilled nurse executive will not be able to realise this potential if the board is not functioning effectively. This programme focuses, therefore, on the interplay between the nurse executive and the board, and how boards can make the best use of their nurse executive to improve the quality of care.

The first phase of the programme took place in 2008 and looked at seven pilot sites from across the UK. A number of themes emerged from our observations, which were published in *From Ward to Board* (Machell *et al* 2009). The following factors emerged as important in enabling boards to engage effectively with the clinical quality agenda.

- Having the right building blocks in place, specifically: the right information; good relationships combined with robust governance arrangements; and strong clinical leadership and clinician engagement.
- Embedding quality assurance across the organisation.
- Having a strong financial footing and a readiness to respond to the changing external environment.

- The availability of certain types of information, which can help to initiate a conversation about clinical quality at board level; we identified five principles that underpin good information on clinical quality.
- Chairs and chief executives who work together to reinforce the importance of clinical quality.
- Making it explicit that clinical quality is an issue for the whole board.
- Where boards rely on other structures (such as sub-committees) to provide assurances about clinical quality, that there are clear and effective flows of information from these to the board.
- Demonstrating the learning environment by valuing and acting on intelligence on the patient experience, including complaints and incidents.
- Demonstrating openness and transparency to public scrutiny at board meetings.
- The role of the chair in creating a climate and culture in which the patient experience can be discussed openly, and acknowledging any discomfort such discussions may cause the organisation.
- Having non-executive directors who constructively challenge executive colleagues and seek assurances that clinical quality is embedded across the organisation.

The first phase of the programme also identified areas in which nurse executives have a key role to play. These include:

- helping to create the right culture and climate to have open discussions about quality
- leading by example and constantly reinforcing the importance of quality to all aspects of the business
- stimulating discussions about what types of information boards want and need to know in order to assure quality
- interpreting hard data and identifying the clinical impact
- serving as a conduit of information about the patient experience, through the use of soft intelligence and narrative
- helping boards to tap into the emotional content of the patient experience
- modelling appropriate behaviours around presenting and receiving feedback from patients.

Where we refer to the ‘successful’ or ‘effective’ nurse executive in this report, we mean nurse executives who can demonstrate a range of competencies and capabilities that were highlighted during the pilot phase of the programme, as well as in the literature (*see, for example, Kirk 2008*). We observed that the following capabilities are important for nurse executives to work effectively with boards to secure quality improvement.

- Being able to talk convincingly about the business of the whole organisation, and not limit their contributions to clinical issues.
- Being able to draw on a wide range of capabilities, and employ a style, tone and body language that reflects authority, confidence and competence.
- Being able to draw on financial and commercial acumen, while retaining their unique clinical focus and emphasis on the human experience.

- Being able to nurture key alliances both within and outside the boardroom, which support them to be more confident and authoritative in discussing clinical quality at board level.
- Being supported by robust reporting processes around clinical quality and a boardroom environment that is open and interested in this agenda.

This report builds on these themes and presents our observations from the second phase of the programme, involving six NHS organisations in England.

We chose an organisational development approach to support nurse executives and their boards, to provide them with ‘real-time’ feedback, and to facilitate the development of models for high-quality, board-level clinician engagement. By this, we mean engagement of anyone with a clinical background, including doctors, nurses and allied health professionals. Appendix A describes the theories that underpin both the programme, and our interventions as consultants.

Summary

This report is based on observations of how nurse executives and their boards work together in six NHS trusts (four acute hospitals and two mental health trusts) in England. It represents the second phase of a programme of work carried out by The King's Fund, in partnership with the Burdett Trust for Nursing, to support nurse executives and NHS trusts to 'bring the ward to the board'. It builds on the themes that emerged from the report of the pilot phase of the programme, *From Ward to Board: Identifying good practice in the business of caring* (Machell *et al* 2009).

The quality of clinical care – what we have termed 'clinical quality' – is an issue for the whole board. Our programme has focused on the interplay between the nurse executive and the board. The reason for this is that, as leaders of the largest part of the health workforce, nurse executives have unrivalled influence over patients' experiences of care. This, combined with a broad portfolio of responsibilities that usually includes clinical quality and governance, makes the nurse executive role vital in bridging the link between the patient on the ward and the boardroom. The approach we have taken includes: observing boards in action; giving them real-time feedback on their discussions, as well as their relationships and processes; coaching nurse executives; and providing nurse executives at each site with a development grant.

During the last year, and since the pilot phase of the programme was completed, there has been a major shift in the importance afforded to the quality and safety of patient care. Many organisations claim they are making improvements in every aspect of quality, yet measures of performance on quality indicate that the NHS is finding it difficult to embed continuous quality improvement. The policy context is not yet conducive to bringing the ward to the board. And there is a real challenge in maintaining the emphasis on quality at a time when the economic downturn means NHS organisations will be operating with considerably tighter budgets for some years to come.

These are our main observations from the second phase of the programme.

Clinical quality occupies a fragile position in many NHS boardrooms

- Factors that can divert attention away from quality include applying for foundation status, and a focus on targets and performance management.
- Engaging with this agenda is perceived as complex and there is confusion about the different tasks associated with it: quality assessment, quality improvement, and quality assurance. The top teams at the sites we visited acknowledged that more could be done to improve clinical quality, but expressed a lack of clarity over *how* to do this.
- Discussing clinical quality can be an uncomfortable experience for boards, and a reactive approach to quality review can leave board members feeling defensive. There is a desire to be able to initiate proactive review of clinical care, but often uncertainty over how to achieve this.

- Quality receives greater attention in the boardroom when its relevance to other aspects of the business – such as financial efficiency and operational excellence – is understood.
- Nurse executives are well placed to help boards integrate quality with other aspects of the business. To do this, they need to ensure that their own influence extends to a broad agenda, including finance, marketing, and commercial issues such as contracting and procurement.

Leadership, culture and having the right systems in place are critical to the ability of boards to focus effectively on the business of caring

- Boards need to set aside time to develop their capabilities around understanding data, as well as the different approaches to and methods for quality assurance and quality improvement. This may require additional training and support for some board members, particularly non-executive directors.
- Chairs must adopt a style of leadership that sets the tone for the organisation. They should have excellent facilitation skills, know how to draw on clinical opinion to best effect, and be able to maintain an unrelenting focus on clinical quality.
- Boards are most likely to succeed in engaging with the quality agenda where they adopt a transformational, proactive style of leadership, based on the co-creation of ideas. In this model, the board is the enabler and collaborator.
- The type of organisational culture that sustains engagement with quality clearly values clinical quality, encourages constructive challenge between board members, defines appropriate behaviours, enables staff to speak out as ambassadors for quality, and emphasises the value of critical reflection by the board.
- Boards that are successful in maintaining a consistent focus on clinical quality are more likely to have the right structures in place to underpin this agenda. These include setting specific aims and commitments around quality (ideally as part of a quality strategy), and dedicating sufficient agenda time to discuss quality.

Nurse executives need to develop their consultancy, coaching and facilitation skills so that they move from their traditional role of 'doing' to one of enabling others

- The most successful nurse executives are skilled facilitators who are able to help non-executive and executive colleagues understand and scrutinise data for clinical quality.
- Nurse executives need to operate tactically – knowing when to intervene, and what tactics to employ, including when to raise strong concerns about particular issues.
- There is uncertainty among non-executives and executives over what a legitimate level of enquiry for non-executives is, and how they can most effectively fulfil their quality assurance role. Nurse executives can help boards to manage the levels of conversation about quality.
- Nurse executives have a key role to play in strengthening board engagement with frontline clinicians (doctors, nurses and allied health professionals), and this can bring numerous gains for the quality of clinical care. However, they should be mindful of the risks attached to adopting an advocacy role for nursing staff in the boardroom.

- Nurse executives are well placed to engage clinicians to lead the development of metrics for measuring high-quality care.
- Nurse executives can assist boards to fulfil their quality assurance role by using both soft intelligence (eg, qualitative information such as patients' stories) and hard data (eg, quantitative data on infection rates).

Ten things that boards can do

We have set out below ten things that boards can do to sustain engagement with quality improvement in the longer term.

1. Set the context for engaging in quality – be clear about what quality means for your organisation, define its relevance to different aspects of the business, and be prepared for the fact that engaging with quality may at times be an uncomfortable experience.
2. Shape the culture and tone of your organisation so that clinical quality becomes the top priority – the board needs to adopt the right behaviours and leadership style, and communicate the value it places on quality to managers and staff, patients and families.
3. Develop a strategy for quality improvement or, at the very least, make explicit commitments in relation to quality.
4. Have a dedicated quality sub-committee to oversee quality assessment, quality improvement and quality assurance, and to reassure the board that these tasks are being fulfilled effectively.
5. Pay attention to dynamic administration, including the length of meetings, the volume of papers, and appropriate breaks. If the basics are not right, the board will not be in a position to give its full attention to quality.
6. Review the use of sub-committees and ensure that the correct breadth and depth of information regularly reaches the board.
7. Put quality at the top of the agenda for board meetings and devote at least 25 per cent of time to discussing quality issues.
8. Draw on a mix of both qualitative and quantitative data to form a rich picture of the quality of care being provided by the organisation, including using patient stories and information from ward 'walkabouts'.
9. Make good use of clinical executives on the board and clinical leaders throughout the organisation to drive the quality agenda.
10. Develop the board's capability to understand and promote continuous quality improvement – non-executives in particular may need support to do this, but also executive directors who do not have a clinical background. This may require building knowledge and skills in quality improvement approaches, quality assurance systems and data analysis.

Introduction

What a difference a year makes. Phase one of our programme of work to support nurse executives and NHS trust boards to ‘bring the ward to the board’ was completed at the end of 2008. During 2009, the profile given to clinical quality and the safety of patient care has been higher than ever. A number of reports have reflected on failings in care (*see*, for example, Healthcare Commission 2009a; Colin-Thomé 2009; Alberti 2009; Mullan 2009; Dr Foster 2009). These have helped to sustain the momentum created by *High Quality Care For All: NHS next stage review* (Department of Health 2008a).

The Secretary of State for Health, Andy Burnham, has set out his aspiration ‘to make quality the organising principle for everything we do’ (Department of Health 2009a), and the NHS has been busy implementing a whole raft of initiatives designed to secure a stronger focus on quality improvement. In England, these include: a new capacity to analyse and act on quality information through the newly established quality observatories;¹ a National Quality Board to align action; the publication of the initial set of Indicators for Quality Improvement (IQIs); and adoption of the QIPP (quality, innovation, productivity and prevention) agenda (Department of Health 2009b).

The NHS Operating Framework for 2009/10 in England outlines priorities for quality improvement, including improving cleanliness and reducing healthcare-associated infections (HCAIs), improving access, and improving the patient experience. In preparation for Quality Accounts in 2009/10, NHS foundation trusts and provider organisations in the east of England have produced quality reports for 2008/9. Commissioners have begun to consider how to use the Commissioning for Quality and Innovation (CQUIN) payment framework locally to encourage quality improvement. Regional initiatives have been developed, such as NHS North West’s Advancing Quality programme.² And metrics to define and measure the quality of nursing care are gathering pace (Nursing Times 2009a) and beginning to demonstrate their value (Nursing Times 2009b).

The Department of Health claims there have been improvements in every aspect of quality (Department of Health 2009a), and undoubtedly there has been a major shift in the importance afforded to the quality agenda. Yet measures of performance on quality indicate that the NHS is finding it difficult to embed continuous quality improvements.

The most recent performance ratings reveal that some acute hospital trusts are struggling to perform well on quality standards, and that compliance with core standards has fallen compared with the previous year (Care Quality Commission 2009).

1 For example, the West Midlands QI aims to become a one-stop shop for information about quality of services. It aims to provide a range of services, including: measuring and reporting on quality across all service areas; reporting at pathway level and for episodes of care; measuring all aspects of quality including clinical process and outcomes, patient reported outcomes, patient experience and whole population health; and working with clinical teams to develop new measures for quality. www.wmqi.westmidlands.nhs.uk/about-wmqi/

2 Claiming to be the ‘first of its kind in the UK’, the Advancing Quality programme was launched towards the end of 2008 to provide incentives to hospitals to improve the quality of patient care. It is a type of pay-for-performance scheme that has been designed to bring about cultural change. The focus is on improving quality in five treatment areas: heart failure, heart attack, heart bypass operation, pneumonia, and hip and knee replacement. www.northwest.nhs.uk/whatwedo/advancingquality/

The previous regulator of health care standards, the Healthcare Commission, found that the performance of NHS organisations on the 12 standards relating to safe care in the Annual Health Check (AHC) was variable, and that the standards for safety and governance had consistently low rates of compliance (Healthcare Commission 2008a). The overall picture is one where the performance of the NHS on safety standards has not consistently improved over the four years of the AHC. This assessment is reinforced by work from Dr Foster (2009), which has found wide variations in safety standards, with patients at some hospitals reported to be at risk from life-threatening errors.

Surveys of nursing staff reveal frustration with the slow pace of change. Just under 70 per cent of more than 500 nurses surveyed by *Nursing Times* believed that the government's drive to increase quality of care had not yet had any noticeable, positive impact on health services. Far from being liberated to lead improvements in quality, 'a large number' of respondents cited managers and their continued focus on meeting targets as barriers to progress on freeing up clinicians to lead improvements (Ford 2009).

The House of Commons Health Committee's inquiry into patient safety concluded that, for all the policy innovations, insufficient progress has been made in making NHS services safer. The Committee observed: 'Boards too often address governance and regulatory issues, believing that they are thereby discharging their responsibilities in respect of patient safety – when what they should actually be doing is promoting tangible improvements in services' (House of Commons Health Committee 2009, p 91).

Indeed, blame for an apparent lack of progress in delivering high-quality care is directed squarely at the boardroom. Poor leadership and governance in relation to the safety of care was a recurrent theme from investigations into service failure and poor performance (Healthcare Commission 2009b). The regulator observed: 'Management has not been effective "from board to ward", and information on outcomes of care has not been routinely reported to the board, analysed and acted upon.' The Commission has also highlighted a tendency for boards to concentrate on other activities such as the delivery of targets at the expense of safety, and an inability to spot problems because of inadequate information systems (Healthcare Commission 2008a).

Despite the policy shift to support quality improvements, it would seem that many boards are struggling to fully engage with the quality agenda. Policy demands have not yet created a conducive environment for bringing the ward to the board. And there is a real challenge in maintaining the emphasis on quality at a time when the economic downturn means that NHS organisations will be operating with considerably tighter budgets for some years to come. Moreover, the pilot phase of the programme suggested that boards do not have the right building blocks in place. Our first report identified three key building blocks: the right information; recognition of the importance of relationships combined with robust governance arrangements; and strong clinical leadership and clinician engagement (Machell *et al* 2009). The absence of any one of these will prevent boards from focusing effectively on the business of caring, whatever the policy context.

From Ward to Board programme

To help boards achieve continuous quality improvement, The King's Fund, with the support of the Burdett Trust, has been running a development programme with nurse executives and NHS trust boards – From Ward to Board. Our focus has been on supporting boards to engage with clinical quality and, in particular, supporting nurse executives to enhance the performance of their board.

For the second phase of the programme, participating organisations were selected by open invitation. We interviewed the chief executive and/or chair and nurse executive of

each potential site. Six trusts were selected – four acute and two mental health trusts, four of which were also foundation trusts – all from England.

The programme consists of the following elements.

- **A diagnostic site visit** to establish how the board addresses issues of quality.
- **Three observational visits** to understand how boards operate in relation to quality. This also enables an assessment of how other issues, such as the chair's leadership style, affect the board's ability to engage with quality issues. Each observation involved giving real-time feedback on the board's discussion, as well as the structures, relationships, processes and other factors underpinning it. During the pilot phase, we looked at what boards were doing on quality. During this second phase, we gave more guidance on what boards could do to improve their performance on quality. Reflecting the issues raised in Lord Darzi's *NHS Next Stage Review*, and a new interest in quality, we responded to requests from a number of boards for practical guidance on how to embed clinical quality, drawing on the most up-to-date evidence.
- **Three coaching sessions with each nurse executive** to boost their impact and effectiveness at board meetings, drawing on observations of their board in action.
- **A £5,000 development grant** for each nurse executive, linking to objectives identified during the coaching and feedback sessions.
- **A nurse executives' seminar** to bring together nurse executives from all six sites to share best practice, establish a network and discuss emerging themes.

Aims of this report

This report aims to disseminate the findings from our work with nurse executives and NHS boards at the six sites involved in the second phase of the programme. It is organised into four sections. Section 1 examines what we mean by the clinical quality agenda and, crucially, why it is often marginalised in the boardroom. Section 2 considers the boardroom environment, including issues of leadership and culture, as well as the systems and processes that underpin how boards work. Section 3 looks at the role of the nurse executive in facilitating the contributions of others, particularly non-executives, in boardroom discussions of quality. It also considers the nurse executive's role in engaging all those involved in providing clinical care (from doctors and nurses to allied health professionals), and in scrutinising data about quality. Section 4 draws together our findings from this phase of the programme. It builds on the themes of the first report, and sets out ten things that boards can do to ensure that they engage more effectively with issues of quality.

1 The subordination of the quality agenda

Continuous quality improvement should be the first priority for all NHS organisations, and their boards should be interested in ensuring that this is happening. In practice, the context in which they operate can easily distract attention from this. Boards of NHS trusts investigated by the Healthcare Commission (2008b) were found to be particularly vulnerable to being consumed by the ‘business’ of health care in the form of mergers, reconfiguration of services, financial deficits and targets. Others have similarly identified a tendency for boards to focus on operational matters and national targets rather than issues of quality and the patient experience (NHS Confederation 2005).

Our observations during the second phase of the programme confirmed that quality can still easily be marginalised in the boardroom. Executive clinicians at some sites felt that the process of applying for foundation status had diverted the board’s attention away from other important matters. A focus on targets and performance management was also perceived to push clinical quality down the agenda. Even making space to discuss quality on a packed agenda was sometimes an issue. We observed boards that would give attention to quality when they had the time to do so but, when they were under pressure, this focus was easily lost.

This section defines what we mean by clinical quality and seeks to uncover the reasons why quality issues are often overlooked in the boardroom.

What is the quality agenda?

One reason why clinical quality may not receive the attention it deserves within the boardroom is that it can appear to be a vague concept, alongside related concepts of ‘patient safety’, ‘patient outcomes’, ‘clinical audit’, ‘clinical governance’, ‘patient experience’ and ‘patient satisfaction’. Some of the participants in the programme called for greater clarity over what is meant by clinical quality.

We did not observe any of the six boards reflecting on what they understood by the concept of clinical quality. In the absence of this kind of conversation, it is difficult for boards to judge whether they are providing high-quality services. A better understanding and description of what constitutes ‘good care’ is one of the lessons from failures in NHS services. The Healthcare Commission (2009b) has reflected that ‘too many of the standards that are set concentrate more on processes than outcomes’.

It is clear from our observations of boards that a variety of concepts are referred to, sometimes with little thought to their emphasis or real meaning. We are mindful of Professor Sir Ian Kennedy’s (2004) observations that terms such as ‘patient safety’, and ‘the patient experience’ risk marginalising the patient. This report seeks to use terminology that serves as a constant reminder that patients, their safety and their experiences, are what quality is all about.

Lord Darzi’s definition focuses on understanding quality from the perspective of patients. It consists of three dimensions: safety, the effectiveness of care, and the patient experience

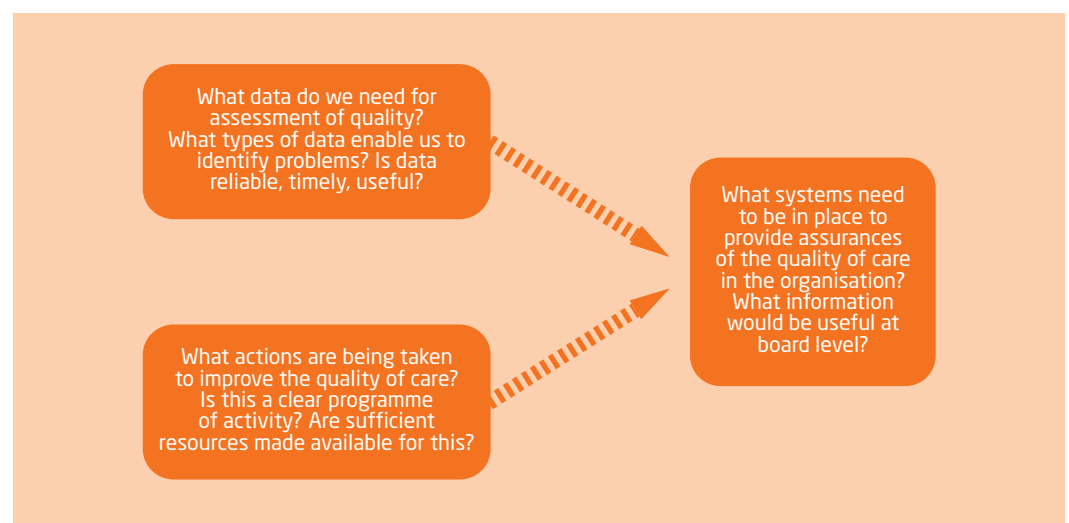
(Department of Health 2008a), and provides a helpful framework in which to think about quality. We observed a tendency for boards to give more attention to the safety of care than the other two dimensions, reflecting that discussions about quality are often very reactive.

This raises questions over the extent to which one dimension of quality can be an indicator of overall clinical quality. Is a service that prioritises the safety of patient care more likely to perform well in terms of effectiveness and the patient experience? The Department of Health thinks not: the NHS Operating Framework for 2009/10 emphasises that the safety of care, the effectiveness of care and the patient experience together make a quality service – ‘not one, not even two, but all three’ (Department of Health 2008b). Certainly, approaching quality from the perspective of ‘doing no harm’ is unlikely to deliver the type of ongoing quality improvement that is needed.

The lack of clarity we observed at board meetings extends to the concept of quality assurance. The Liverpool School of Tropical Medicine offers a helpful definition, describing quality assurance as ‘a planned and systematic approach to monitoring, assessing and improving the quality of health services on a continuous basis’ (Liverpool School of Tropical Medicine 1999). Two structural elements of quality assurance are identified: quality assessment, and quality improvement and control. Separate systems and processes need to be in place for these distinct elements.

Quality assessment is essentially about identifying areas for improvement. For example, the assessment of quality may involve examining clinical audit data, complaints or nursing care indicators to detect failures in quality. *Quality improvement* is about resolution and setting continuous quality improvement goals. So, for instance, quality improvement actions could involve scrutiny of service redesign using ‘lean thinking’ or the development of the productive ward (NHS Institute for Innovation and Improvement 2009). *Quality assurance* brings these two things together, with the aim of building accountability and confidence. Quality assurance may involve receiving reports and feedback at board or committee level about the processes in place to assess quality and oversee quality improvement actions. Figure 1 below outlines questions boards may wish to consider with respect to each of these tasks.

Figure 1 Assessment, improvement and assurance – questions for boards to ask



Our interest is in the skills, knowledge, resources and capabilities boards need to monitor and assure continuous quality improvement. Few would argue against these aspirations, so what makes achieving them so tricky?

Why do boards find it difficult to engage with quality?

Trusts are committed to delivering high-quality clinical care, but measuring and assuring quality is complex. The top teams at the sites we visited acknowledged that more could be done to improve clinical quality, but were unclear about *how* to do this. Some conversations reflected concern about ‘keeping quality alive’ without becoming burdened by processes, and a need to get quality embedded into boardroom agendas in a creative way.

The perceived difficulty of assuring quality is linked to an issue about board capabilities, in terms of both the information they have on quality and also how board members work together to bring quality issues alive. There is an educational task in helping board members, and non-executives in particular, to get ‘stuck in’. Section 2 explores in more detail the factors that affect a board’s ability to do this.

We also observed confusion among boards over the distinction between quality assessment, quality improvement and quality assurance. For example, we observed situations where the patient experience was brought into the boardroom without sufficient explanation as to what it was intended to illustrate – that is, was it intended to provide a snapshot of care on the ward (quality assessment), to reveal areas where improvements were needed (quality improvement), or to assure the board of improvements that had already taken place (quality assurance)? Boards also tend to focus on data for assessment purposes, which reflects a lack of clarity about the ongoing need to embed quality improvement. We also observed a tendency to ‘close’ an issue because ‘we did that last time’, or that the end result for the organisation is to benchmark well compared with others.

Throughout the programme, we have observed that it is easier for NHS organisations to focus on quality when there is a clear mandate for doing so – because patient care is falling below accepted standards, or patients have been harmed. Hence, boards tend to engage in clinical quality in a reactive rather than proactive way, which often leaves them feeling defensive. There is a desire to adopt a more proactive review of clinical care, but uncertainty over how to achieve this.

Another reason why boards find it difficult to engage with the quality agenda is that discussions about quality can be uncomfortable, as the patient experience may show the organisation in a negative light. Unless this discomfort is acknowledged and managed, it can discourage pursuit of the quality agenda and may contribute to a perception that the board is not interested in quality. This is especially true of boardrooms that are characterised by transactional leadership (ie, command and control) and where conversation tends not to be challenging or questioning. An example would be the nurse executive explaining a serious incident in terms of the failure of one person, suggesting that ‘if that person had behaved differently, this would not have happened’.

All boards have a ‘strategy ceiling’ (Boxer and Palmer 1997), whereby there is an unspoken understanding about what can and cannot be discussed in the boardroom. This ceiling is reinforced when some board members feel unable to ask more penetrating questions. We believe the chair has a particular responsibility for judging where the ceiling is set, and not allowing it to prevent relevant information such as patient stories being brought into the boardroom. We have observed that some chief executives keep the strategy ceiling low by arguing that more in-depth conversations do and should take place in the sub-committees.

Boards with a low strategy ceiling are characterised by a failure to ask basic questions about serious incidents, such as ‘Why did this happen?’. Conversations that consider what went wrong, what events led to the incident and the context in which it occurred

actively pursue the ‘why’ of a serious incident or other agenda item. We know that such conversations will be challenging, as people may have to explore areas that they do not know or understand. Again, this requires encouragement from the chair in particular. We also know that knowledge is valued over ignorance. Knowing how to acknowledge that you do not fully understand something is an underrated skill (Argyris 1986), with the result that non-executives in particular can hold back from asking probing questions because they do not wish to appear stupid. However, some argue that smart people need to be able to admit when they do not understand an issue, otherwise they risk replicating outdated and ineffective approaches (Schein 2004; Argyris 2000).

Clinical quality is more likely to be a priority on the board agenda where its relevance to the business of running the organisation is clearly understood. The quality of clinical care *is* the business of NHS organisations, yet one nurse executive remarked that boards may not fully understand the complex dynamics that comprise the ‘business of caring’. These include the relationship between financial efficiency, operational excellence and quality improvement. Where we observed boards linking quality to other aspects of the business, such as performance and efficiency, the board was able to engage more effectively with quality issues (*see* box below). The sites that were successful in this respect had thought through the business case for focusing on clinical quality – for example, by seeking to expand market share, reputation and reach on grounds of quality.

Productive theatre project - linking quality to income

The importance of quality was reinforced at one site by a presentation that linked issues of patient care to revenue-earning potential. The board meeting began with a presentation by the clinical team leading a productive theatre project. The aim of the presentation was to engage the board in the project, which was described as having ‘a huge influence on patient outcomes’. The team highlighted the fact that theatres were the key income-generating activity for the hospital, and linked this to the need to provide a safe, effective service for patients.

The presentation had a clear focus on quality improvement, including improvements in clinical leadership. It was also a good example of clinical engagement by the board, whose members appeared engaged and informed, and were able to discuss the clinical service and raise pertinent questions.

Nurse executives are in a good position to help boards link clinical quality with other aspects of the business. Their role requires them to have a thorough understanding of the business of caring, and they are professionally accountable for nursing staff. They tend to have a broad portfolio of interests; for example, the portfolio of one nurse executive in the programme included capital projects, business development and marketing.

There are issues about the balance between strategic and operational responsibilities, and the extent to which certain responsibilities support or hinder the nurse executive’s ability to push forward the quality agenda (Machell *et al* 2009). But, ultimately, a broad focus can help the nurse executive take a whole-system view of quality and link it with other areas of the business. During our observations, nurse executives were most effective when they were able to contribute their expertise to a broad range of agenda issues, including finance, marketing and procurement of contracts, as well as issues of quality and safety.

However, there can be a downside to nurse executives being too strongly associated with the quality agenda. We are concerned that nurse executives may be left to shoulder the responsibility for quality when it should be an issue for the whole board and, indeed, the whole organisation. There is also a danger that the quality agenda can undermine the status of the nurse executive, and vice versa. Our first report highlighted how some nurse

executives felt that their nursing background, although giving them a unique oversight of the quality of clinical care, could subordinate their position in the boardroom. Others have similarly uncovered a perception by nurse executives that the pervasive view of nursing in the NHS is as a subordinate, submissive profession (Faugier and Woolnough 2001). It may also point to a lack of gender diversity in the boardroom.

If nurse executives find it difficult to assert their position in the boardroom, aligning themselves too closely with the quality agenda may not help to improve their own credibility. Moreover, where executive and non-executive colleagues perceive the nurse executive role as subordinate, linking the role too closely with quality may make it more difficult for the board to engage effectively with the quality agenda. This is illustrated by a comment from one chief executive, who described the nurse executive as ‘wanting the board to focus on the fluffy stuff’.

For both nurse executives and the quality agenda, the key to gaining a stronger foothold in the boardroom appears to lie in extending their input to a broad agenda and reinforcing their relevance to all aspects of the business. Nurse executives need to establish their presence across the breadth of discussions to ensure that, when they do raise clinical issues, they are not downgraded or marginalised. This means supporting nurse executives to establish and sustain their authority. This – and the need for a range of facilitation skills – is all the more important as the context in which they try to advance the quality agenda can be ambivalent. Equally, boards need to look at quality not only in relation to the safety and effectiveness of care, but also its relevance to financial and commercial aspects of the business.

Key messages

- Clinical quality occupies a fragile position in many NHS boardrooms.
- Engaging with this agenda is perceived as complex and there is confusion about the different tasks associated with it: quality assessment, quality improvement and quality assurance.
- Discussing clinical quality can be an uncomfortable experience for boards. A reactive approach to reviewing quality can leave boards feeling defensive.
- A board’s ability to engage effectively with quality is strengthened by efforts to link it with other aspects of the business, such as financial and operational efficiency.
- Nurse executives are well placed to help boards integrate quality with other aspects of the business. To do this, they need to ensure that their knowledge and influence extends to a broad agenda.

Coaching points for nurse executives

How can you help your board to differentiate between quality assessment, quality improvement and quality assurance?

How can you help your board to adopt a culture of continuous quality improvement for the organisation? How can you align nursing care strategy with a drive for continuous quality improvement?

What can you do to integrate the quality agenda with other aspects of trust board business?

What can you do to manage board members’ anxieties when discussing issues of quality and safety?

2 Inside the boardroom

We have highlighted the vulnerable position that clinical quality often occupies in NHS boardrooms, and some of the reasons that lie behind this. Much rests with the board's ability to work together as a group to bring this agenda alive. As a consequence, much has been written about boardroom governance. Some of the most recent guidance includes: *The Intelligent Board* (Dr Foster 2006); the *Integrated Governance Handbook* (Department of Health 2006); *The NHS Foundation Trust Code of Governance* (Monitor 2006); *Code of Conduct: Code of accountability in the NHS* (Department of Health 2004); and *Taking it on Trust* (Audit Commission 2009a). Such reports pinpoint a range of characteristics associated with effective NHS boards. These generally reflect three common building blocks of effective governance: leadership, culture, and having the right systems and processes in place. We have found that these three themes are critical to the success of boards in focusing effectively on the business of caring.

What style of leadership has most influence on quality?

NHS boardrooms set the tone for the services that their organisations deliver to patients. As Goodrich and Cornwell (2008, p 36) observe:

The actions and words of senior hospital leaders – by which we mean board members, senior executives and senior clinicians – have a profound influence on what happens to patients. They shape the culture of the hospital; the priorities of managers and staff; how they behave, towards each other and towards patients and families; and how staff feel about the services they provide and the organisation.

So how does a board learn to set the right tone? Mostly this is acquired on the job – an apprenticeship model. However, the risk with this sort of learning is that norms are internalised without critical evaluation, because people who are new to the organisation are worried about being excluded. Non-formal activity – such as space to tackle problems, explore solutions, gain skills, and learn together – is therefore important to develop the skills and attributes board members need to deal with clinical quality issues. But our observations suggest that boards do not regard developing their capability to oversee issues of clinical quality as a priority.

Reinertsen *et al* (2008) remark that the best health boards in the United States bring in members who are experts in quality methods from manufacturing and other industries, and invest in educating all members in these areas. The House of Commons Health Committee (2009) recommended that non-executives in particular undergo specialist training in patient safety issues. We would go further and recommend that training should focus on developing a quality improvement orientation within the board, including competence building in quality improvement approaches, quality assurance systems, and skilling up in data analysis.

Much rests with the leadership style of the chair. As Bevington (2004) points out:

Chairs must be relentlessly sensitive to their own style of leadership, in particular, ensuring that their words and actions are aligned, and that they work consistently

towards nurturing these behaviours in others, especially among non-executives. They must also be ever vigilant to events and decisions that could harm or even destroy trust and challenge at board level.

Based on our observations, some chairs are accomplished at this, but others did not have the leadership skills to create the right culture and facilitate board dynamics. Some chairs struggled to get the basics right, in terms of introducing agenda items well and accurately summing up discussions that had taken place.

Where we observed strong chairs at the helm, they demonstrated excellent facilitation skills and were able to incorporate everyone's views, maintain momentum, encourage debate and sustain a focus on clinical quality. Effective chairs knew how to draw in clinical opinion to good effect, and were skilled at asking penetrating questions around quality, as well as making their own views known. One chair we observed was outstanding in this respect, asking questions such as: 'Have we got clusters of problems, and if so, where?'; 'We take finance monthly, why not complaints?' and 'We need trend analysis and to triangulate the data. We are not just here to defend our boundaries and territory, we are here for patients.'

A great deal has been written about the importance of the relationship between the 'two at the top' (see, for example, NHS Appointments Commission 2003; Robinson and Exworthy 1999). Our observations revealed the influence that this relationship can have on the effectiveness of the board. For example, at one site, the style of communication between the chair and chief executive and the rest of the board served to heighten anxiety among board members. The chair and chief executive seemed to use the board as a dumping ground for generalised anxiety, without offering any clear plans for how to resolve the issues causing concern.

However, our observations also suggest that three individuals rather than two may determine the degree to which the board engages effectively with clinical quality. We witnessed the strong influence that the chief operating officer can have on the boardroom agenda and dynamics. At one site, the chief operating officer appeared to have considerable control over the agenda, which constrained the nurse executive's ability to highlight issues of clinical quality.

More generally, the nurse executive's relationship with the chief operating officer – and that individual's attitude to evaluation of their practice and decisions – may be critical in sustaining authority, given the latter's control over resources that mediate patients' experiences of care. The nurse executive's interventions will inevitably question the actions of the chief operating officer. How such challenges are managed will depend on the culture that has been created by the chair and chief executive. However, we also witnessed how a collusive relationship between the chief executive, the chair and the chief operating officer, coupled with dysfunctional board dynamics, led one trust into very difficult territory, with failure to comply with targets and the threat of regulatory intervention. It also seriously undermined the work of the nurse executive.

It seems that some boards still operate according to the 'old school', top-down style of leadership, which is underpinned by a command and control mentality, and a reluctance to trust each other. In contrast, the clinical quality agenda is best supported by a model of leadership that is based on the co-creation of ideas (about quality improvement). In this model, the board plays the role of enabler and collaborator. This style of 'transformational' or 'engaging' leadership is characterised by Alimo-Metcalfe *et al* (2007) as demonstrating 'a culture based on integrity, openness and transparency, and a genuine valuing of others'. They found that an engaging style of leadership is crucial to achieving success, and has a significant effect on organisational performance (for example, by predicting positive staff attitudes towards work).

Others have similarly found that sustained attention by boards to staff well-being and morale can pay dividends in terms of patient care. The Clinical Governance Board Support Team (formed in 2000 as part of the NHS Clinical Governance Support Team) observed that the best-performing boards ensured that staff felt valued, empowered and supported: 'It is front line staff (both clinical and support) who translate strategy, intention and aspiration into concrete quality of care' (Stanton 2006).

Nurse executives working in an organisation with a command and control style of leadership are likely to find it harder to assert the quality agenda. In these cases, the challenge for the nurse executive is to nudge the board towards a leadership style that supports and encourages a focus on quality improvement, by demonstrating this style of leadership themselves. However, some nurse executives cited limited opportunities to influence their chair, while others voiced dissatisfaction with the relationship they had with their chief executive. This is where collaboration with executive colleagues, particularly executive clinicians, as well as wider clinical engagement, can help the nurse executive to pursue the quality agenda.

What type of organisational culture sustains engagement with quality?

One of the most important leadership tasks is to nurture the right kind of culture within an organisation. By this, we mean the attitudes, beliefs and values that characterise an organisation. A useful definition of organisational culture is:

... the specific collection of values and norms that are shared by people and groups in an organisation and that control the way they interact with each other and with stakeholders outside the organisation.

(Hill and Jones 2001)

Where failures in clinical care have been identified, often these have been associated with a culture in which staff felt unable to speak out on behalf of their patients (Healthcare Commission 2008b). Our observations enable us to draw some conclusions about the type of organisational culture that is best able to sustain engagement with clinical quality and promote continuous quality improvement throughout the organisation.

First, the organisational culture must clearly value clinical quality. This might be demonstrated by putting quality issues first on the agenda of board meetings, or by the depth and breadth of items about quality. At one board meeting, the nurse executive at one NHS trust (that was not taking part in this phase of the programme) presented no fewer than seven reports on clinical quality, including the patient experience, infection control, essence of care audit results and ward walkabouts. This said a great deal about the value the board placed on issues of quality.

Second, there must be an organisational culture that promotes constructive criticism at board meetings and does not tolerate inappropriate behaviour. It is difficult for board members to engage with quality when some of their colleagues may divert attention away from the real issues. At two of the six sites, we observed board members disrupting discussions and having an overbearing influence, which had a negative impact on board dynamics. Why some board members should behave like this, and why this behaviour is tolerated, is difficult to understand. Boards are, of course, under considerable pressure to contain quality deficits, and may be reluctant to discuss the difficulties involved in reducing costs and improving quality. Such pressures may result in people feeling unable to speak out or challenge their colleagues' behaviour.

The third characteristic of a culture that best sustains engagement with quality is one in which equal measures of challenge and support between board members is encouraged. Some of the non-executives we observed made challenging contributions but were also supportive of their executive colleagues. However, we also observed reluctance by some non-executives to question each other or build on each other's contributions.

There has long been a tendency for executive board members to limit their contributions to their own area of responsibility, leading to a lack of executive-to-executive challenge (NHS Confederation 2005). We observed how this can undermine quality at one site, where the nurse executive told the board that she was unable to provide assurances about the very processes that she was leading and reporting on. None of her boardroom colleagues challenged this. This reinforces the critical role of the chair in establishing and maintaining the kind of culture that encourages constructive challenge. The chair needs to lead by example, in terms of how they introduce items, bring in contributions from others, manage feelings and conflict, and act as a catalyst for challenge.

Fourth, boards need to foster a culture in which board members are able, and keen, to critically reflect on their performance. The ability of boards to critically reflect on their performance is an important theme to emerge from this phase of the programme. It manifested itself in the way that some boards responded to the real-time feedback we gave them. Inevitably, feedback may be difficult to receive if a board assumes that what it is doing is correct. Some boards initially questioned the validity of our commentary, but in subsequent feedback sessions they were more able to accept and use the observations we made. Are boards reluctant to discuss things other than what has gone well? Do foundation trusts, in particular, as high-performing organisations, really want to know if they may not be performing well or where they could improve?

Boards have a dual task: they need to pay attention to what they are doing, but also *how* they are doing it – in other words, to evaluate how the organisation is performing. NHS boards have traditionally paid little attention to their own development or to reviewing their effectiveness. As Bevington (2004) points out: 'Few work groups have their performance assessed less rigorously and frequently than do NHS boards.' He adds that critical corporate self-appraisal is a process, not an isolated event. This is something that nurse executives are well placed to help boards with, given the emphasis in their clinical background and training to be critically reflective of their own practice. For board members, it means overcoming a 'learning anxiety', which comes from a reluctance to talk about things that are not going well or issues that they do not fully understand (Argyris 1991). The box opposite sets out some questions that boards should regularly ask themselves when reflecting on their performance.

A board's culture is often evident in the language it uses. For example, repeated use of the term 'going forward' can undermine the importance of critical reflection, which requires a willingness to step back and review. The concept of dashboards suggests monitoring and simultaneous forward motion, and again, may be indicative of attitudes towards critical reflection. Some boards behave as if words such as 'governance' and 'assurance' describe activities that are directly related to what is going on at the point of service delivery. The use of such words may cover up rather than expose areas for development or questioning. Boards need to consider what is necessary to enable them to allow, for example, the patient voice to be present in the boardroom, and for a very different discussion to happen.

Finally, a culture that sustains quality is one in which staff at different levels of the organisation feel able to voice concerns about clinical care, and in which all staff feel able to speak out as ambassadors of clinical quality. In other words, it is a culture that discourages scapegoating. We observed one board discussion about who should be held

Questions boards should regularly ask themselves

How effective are we as a board? What have been our biggest achievements over the previous year? What could we have done better?

Do we have the right balance of skills around the boardroom? Where are the gaps?

What style of leadership does the board use? How successful are we in promoting this style of leadership across the organisation?

How do staff, patients, the public and other stakeholders perceive the board? Are we doing enough to listen to their views? Are we doing enough to inform others about our work?

Could we improve the way board meetings are run (for example, length, venue, format, room layout)?

Does the agenda adequately reflect the things that we need to give attention to? Are there sufficient opportunities for board members (and non-executives in particular) to influence the agenda?

Are board papers relevant and informative? Do we have the right information to inform decisions and carry out our functions adequately? Is enough time set aside for discussion?

Do we challenge each other enough? Do non-executives feel able to challenge executive colleagues? Do executives challenge each other?

Are our governance structures effective? Do sub-committees provide sufficient assurances to the board? Should the board be reviewing certain information that is currently delegated to sub-committees?

Do we know enough about the quality of care delivered to patients and their relatives by our organisation?

Are we meeting the needs of our most vulnerable patients, and do we have sufficient assurances that they are safe from harm and receiving high-quality care?

accountable for poor quality. In the absence of the right systems and process, the board was moving towards blaming an individual. It is inevitably the case that boards may feel a great deal of pressure to 'name and shame'; however, the NHS Patient Safety First Campaign, for example, starts from the assumption that an incident is unlikely to be the fault of one individual, and is much more likely to reflect the interactions of a number of people and systems. The discussion we observed did not include challenging questions such as 'What events led to this incident?' and 'How can our organisation learn from it and prevent the same thing happening again?'

What systems and processes support a focus on quality?

Boards that are successful in maintaining a consistent focus on clinical quality are more likely to have the right structures in place to underpin this agenda. Examples of the types of structures that we have come across include appointing a quality project manager to oversee a programme of work, time out for the board to reflect on enhancing its focus on quality, introducing quality metrics, and ward walkabouts. Perhaps the most important structure that boards can introduce is a dedicated clinical quality strategy, as a framework for all other systems and processes around quality improvement. This provides a coherent approach to embedding continuous quality improvement across the organisation,

together with targets and outcomes by which progress can be measured. This is one of seven key leverage steps associated with organisations that are successful in sustaining a commitment to quality improvement (*see box below*). Appendix B sets out the core components of a quality improvement strategy.

What boards can do: seven key leverage points

The Institute for Healthcare Improvement (IHI) in Massachusetts has found that where organisations are getting significant results in terms of quality improvements, several key leverage points appear to be in place (Reinertsen *et al* 2008). These leverage points require boards to do the following.

1. Set specific aims and make explicit commitments to quality, and oversee progress at board level.
2. Develop a strategy for delivering these commitments, and ensure that the executive team executes the strategy.
3. Provide a leadership focus on system-level improvement.
4. Involve patients and relatives in quality improvement.
5. Integrate quality improvement with finance – make the finance director a quality ‘champion’.
6. Engage clinicians in quality improvement.
7. Develop quality improvement capability, skills and orientation.

It may be helpful to consider the self-assessment tool that Reinertsen *et al* have developed to help boards work through these leverage points and plan actions arising out of them. This is available at www.ihl.org

Other important initiatives include making space for quality on the boardroom agenda. Evidence from the United States has found that top-performing hospital boards (those in the top deciles of Hospital Quality Alliance performance) were more likely to have quality on the agenda at every meeting, and to spend at least 20 per cent of board time on quality. The poorest performers were more likely to spend at least 20 per cent of board time on finance (Jha and Epstein 2009). Others have recommended that NHS boards should spend approximately 25 per cent of their time addressing issues of safety and quality of care (Patient Safety First Campaign 2008), or *at least* 25 per cent of time on it (Reinertsen 2007). As Reinertsen observes: ‘Through this basic practice, the board sends a powerful signal: “We’re paying attention to quality.” What the board pays attention to gets the attention of management. And what management is paying attention to tends to be noticed throughout the organisation.’

We also observed that boards that maintained a consistent focus on quality had paid attention to the dynamics of the meeting – that is, ensuring things like an appropriate environment for meetings, a room layout that enabled board members to make eye contact with each other, and regular comfort breaks. These small details can make an enormous difference to the quality of board discussions and their ability to focus on the business of caring. We observed good practice at one site in particular, where there was sufficient time allocated for discussion, with focused, relevant papers, and a meeting room layout that supported engagement of all board members.

Where boards are not getting the basics right, it is harder to sustain a focus on quality. For example, we observed one board where members sat behind laptops, which served as a distraction and impeded their ability to engage in any type of conversation. Chairs and chief executives have a key role to play in ensuring that reporting on standing items related to quality is sufficient to sensitise non-executives in particular to the quality agenda, and that the right balance is struck with other aspects of the business, such as finance.

In our report on the first phase of the programme (Machell *et al* 2009), we raised concerns about pre-meetings by executives in advance of board meetings, and their ability to stifle challenge in the boardroom and undermine the relationship between executives and non-executives. In this phase of the programme, we observed that such pre-meetings, if not carefully managed, can also undermine discussion of the relationship between different aspects of the business at the main board meeting. For example, at one site, an executive pre-meeting scrutinised data on finance and performance. As a consequence, there was very little reference to finance and performance at the main board meeting, and an opportunity was lost to integrate quality with these other aspects of the business. At other sites, minimal exchanges in the boardroom reflected arrangements whereby the detail was worked out in committees and could not be discussed at board meetings because of time pressures. The success of an approach whereby detailed scrutiny takes place at sub-committee level relies heavily on the performance of sub-committees, which tends to be something of an unknown.

Feedback loops are central to the ability of boards to improve their performance on quality. As Reinertsen *et al* (2008) remark: 'It is impossible to over-emphasise the importance of the data feedback loop that boards use to oversee the achievement of system-level aims.' Feedback comes from numerous sources, including regulators, the public, staff surveys, whistle-blowing, walkabouts, patients' stories and narrative using PALS (Patient Advice and Liaison Services), reports from LINKs (Local Involvement Networks), and governors' feedback, as well as through data on serious incidents, complaints and mortality. There are issues around how and whether such feedback reaches the board (or whether it is dealt with at sub-committee level), and the degree to which data is so high level that it loses its impact in terms of quality improvement and assurance. According to Reinertsen *et al* (2008, p 9), the fundamental question that feedback data should answer is: 'Are we improving, and are we on track to achieve our aims?'

It is our belief that closing the feedback loop means NHS boards providing assurances around quality openly and in public. Opportunities to do this are undermined by the decision taken by many foundation trusts to hold board meetings in private. We have observed that holding entire board meetings in private can affect the tone and content of what is discussed. This decision no doubt reflects some anxiety about sharing unflattering data with external observers. Minister of State for Health Services, Ben Bradshaw, told the House of Commons Health Committee that he had been considering giving the Department of Health more power to intervene in foundation trusts over refusals to meet in public (House of Commons Health Committee 2009), and the Health Committee concluded that the public should be excluded from board meetings only in exceptional circumstances. One foundation trust involved in our programme had decided to hold meetings in public once again, in response to criticisms about holding board meetings in private.

Boards are regularly tested on their commitment to quality and safety – for example, when quality failings become evident internally or external regulators inspect standards within the organisation. It is when problems occur that it is particularly important for boards to hold the line and demonstrate an unswerving focus on quality improvement;

what Reinertsen calls ‘constancy of purpose’. He gives the following advice to boards: ‘The question is not *whether* the board will send a cultural signal. The question is whether you will send the *right* signal. Don’t flinch’ (Reinertsen 2007, p 11).

A key mechanism for maintaining such constancy of purpose is to establish a committee to oversee quality. Reinertsen argues that this makes a strong statement about the permanence of quality as a key organisational strategy, and reduces the likelihood that the board’s attention will stray to other matters. He highlights a number of features of the best hospital board quality committees in the United States. These include: having the chair as a lead member of the committee to reinforce the importance of its work; appointing non-executives with expertise in quality; an agenda driven by board members of the committee; beginning the meeting with a patient story to illustrate the data to be discussed; vigorous conversations with clinical leaders; consideration and approval of policies and strategies to improve the likelihood of achieving quality and safety aims; and a quality committee report to every board meeting.

Key messages

- Boards need to set aside time to develop their capabilities around understanding data, quality assurance and quality improvement approaches and methods. This may require additional training for some board members.
- Chairs must adopt a style of leadership that sets the tone for the organisation. They should have excellent facilitation skills, know how to draw on clinical opinion to best effect, and be able to maintain an unrelenting focus on clinical quality.
- Boards are most likely to succeed in engaging with the quality agenda where they adopt a transformational, engaging style of leadership.
- The type of board culture that sustains engagement with quality clearly values clinical quality, encourages constructive challenge, defines appropriate behaviours, enables staff to speak out as ambassadors for quality, and places emphasis on critical reflection.
- A number of processes can help to maintain a consistent focus on clinical quality, including setting specific aims and commitments around quality, ideally as part of a dedicated quality strategy. Boards that get the basics right are in a better position to sustain a focus on quality.

Coaching points for nurse executives

What is your style of leadership? Does this style support engagement with clinical quality?

How are you able to influence the leadership style of the chair and chief executive?

What can you do to help your board undertake critical reflection?

How can you help your board to develop its capabilities around quality improvement and quality assurance?

How do the systems and processes that you are responsible for support a focus on quality?

What can you do to strengthen feedback loops to your board?

3 The nurse executive as facilitator – managing relationships with others

Goodrich and Cornwell (2008) note that policy-makers ‘have singled nurses out as more responsible than other groups of staff for patients’ well-being’. While the quality of nursing care is integral to the quality of clinical care generally (particularly in acute settings), many other factors also impinge on clinical quality, from new patient pathways to technology that enables patients to better manage their own health. The successful nurse executive is therefore able to demonstrate leadership around clinical quality within, but also beyond, the sphere of nursing. This section explores how nurse executives can facilitate boards to engage with clinical quality.

Our first report identified a range of capabilities that nurse executives need to demonstrate in order to be both effective and credible (Machell *et al* 2009, pp 29–30). These included: synergy with the political agenda; an ability to unite staff; emotional intelligence; commercial acumen and business skills; and an ability to effectively balance operational issues with strategic ones. During the second phase of the programme, the nurse executives that had the greatest impact had a rich mix of knowledge, experience, focus, political acumen, personal presence and authority. Of course, their impact depends not only on their commitment and capabilities as individuals, but also the context, culture and controls in which they operate. A highly skilled nurse executive is thwarted by a board that is not functioning effectively. However, our observations of nurse executives in boards that are underperforming suggest that the capabilities of the nurse executive can go a long way to overcoming the limitations of the organisational environment.

A review of the literature by Kirk (2008) identified 10 key factors associated with the effectiveness of nurse executives (*see box overleaf*). Based on our observations, nurse executives need to prioritise building their skills in the following areas:

- the presentation of data
- understanding financial reports
- preparing for board meetings
- demonstrating leadership of the safety and quality agenda.

In essence, nurse executives need to develop their consultancy, coaching and facilitation skills to enable them to move out of their traditional role of ‘doing’ to one of enabling others.

Factors associated with effective nurse executives

1. Powerful, influential operator
2. Communication
3. Knowledge of nursing
4. Human management skills
5. Total organisation view, visionary
6. Quality management
7. Business astuteness
8. Collaborative effectively in multidisciplinary teams
9. Providing nurses with the right tools and resources to do their jobs
10. Project management skills

Source: Kirk 2008

Engaging non-executives on quality

The role of the nurse executive as the lead for quality, safety and communicating the patient experience is now firmly embedded and more clearly defined than during the first phase of our programme. Nurse executives are therefore well placed to harness the potential of non-executives to serve as quality champions. The nurse executives at two of the sites we observed highlighted this as a key personal challenge.

Our observations of the pilot sites revealed a need for nurse executives to help non-executives develop their understanding of the processes for assuring clinical quality. One of the themes that emerged during the first phase of the programme – that non-executives often do not know what questions to ask or how to challenge the information they are presented with – continued into the second phase. Non-executives at one board meeting were observed asking searching questions, but not when it came to issues of quality. One non-executive said: ‘I make the assumption that it [quality] is OK!’

One of the issues we identified through our observations was a reluctance on the part of some non-executives to question each other or build on each other’s interventions. For example, at one board meeting, a non-executive member single-handedly pursued questions about the organisation’s non-compliance in relation to safeguarding. None of the other non-executives built on their colleague’s interventions, and so missed an opportunity to pursue in detail an important issue of quality, safety and accountability. At another site, non-executives had a habit of doing set pieces, with little opportunity for discussion, as if a silent rule was in place not to disagree with each other. At a third site, the medical director reported that non-executives tended to raise clinical issues outside of board meetings, suggesting a lack of confidence in their ability to do so in the boardroom. This medical director acknowledged: ‘If the non-executives raise their game, then I will have to raise mine.’ Elsewhere, non-executives exhibited a lack of confidence, prefacing their interventions by suggesting that they were in some way ‘stupid’. Their level of knowledge about clinical matters may determine non-executives’ willingness to engage in conversation about such issues.

In our first report, we questioned the ability of non-executives to interrogate data, compare indicators and analyse issues, and how well boards were equipped to support

them in doing this. This area of concern has continued as a theme during the second phase of the programme.

Underpinning all this is uncertainty over what is a legitimate level of enquiry for non-executives. Emphasis is placed on their ability to retain a strategic, high-level focus. The body responsible for appointing non-executives instructs them thus:

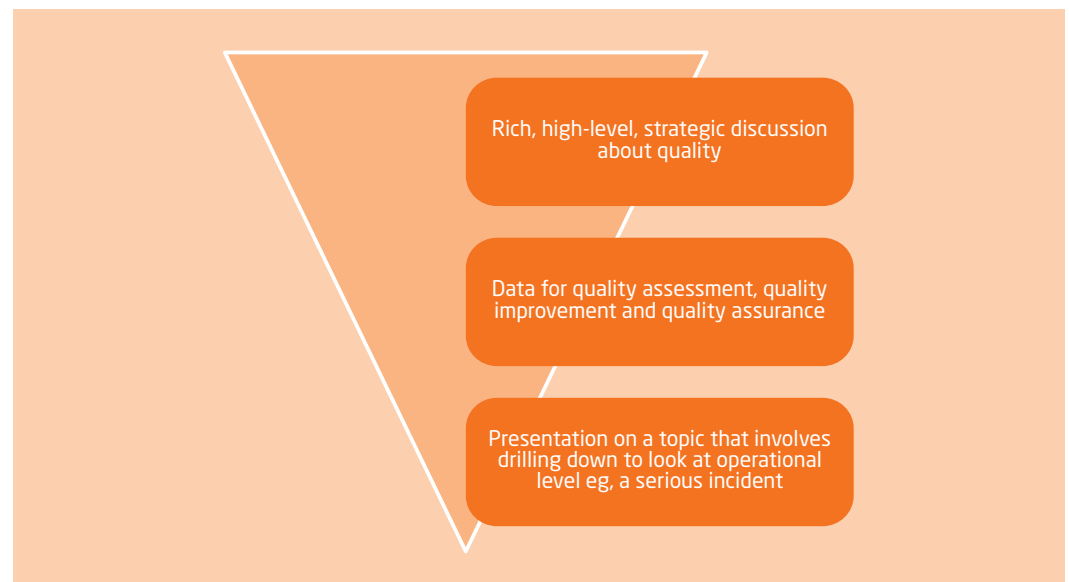
Sometimes there can be a narrow dividing line between strategy and operational management and non-executives need to be careful not to be drawn across this boundary. To do so risks them becoming distracted by the operational detail and thereby unable to maintain the distance and objectivity needed for their role in scrutinising performance

(NHS Appointments Commission 2003, p 23)

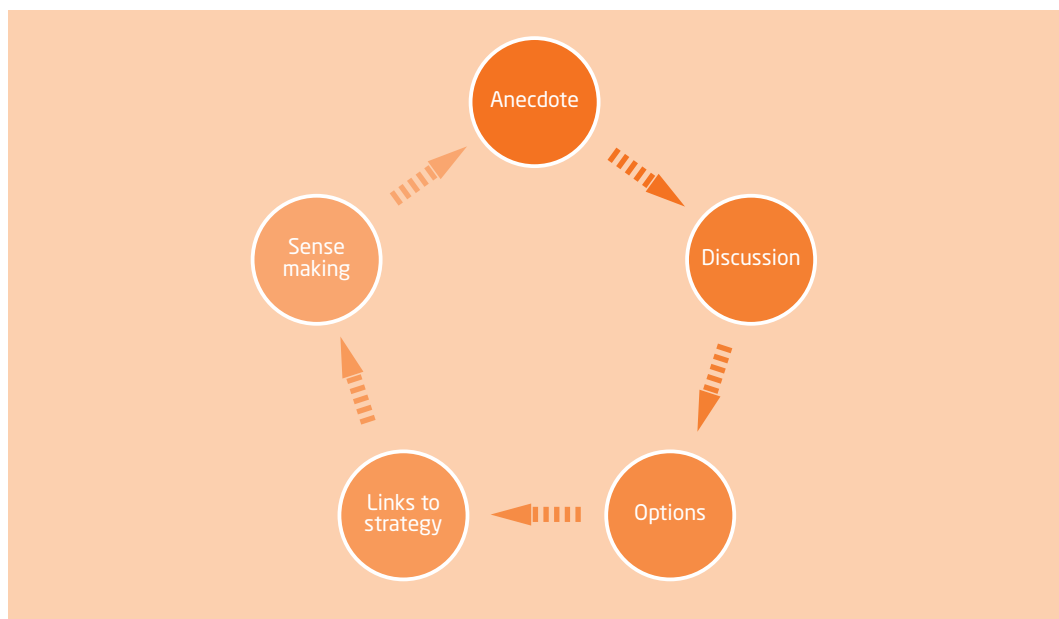
This emphasis can make it difficult for non-executives to find out what they need to know to understand the quality issues facing the organisation. Generally, we observed that non-executives did not want to know the detail. But at one site, a non-executive had taken the role of overseeing how complaints from patients were handled by the organisation and was fulfilling an ombudsman-type role. Such close involvement in the operational mechanisms for assuring quality risked undermining the ability of this individual to stand back and scrutinise quality improvement. If boards get too involved in the detail, they are not asking themselves the right question, which is: how do we create the right environment that supports quality and service improvement?

Nurse executives can have most impact here by facilitating boards to manage the levels of conversation about quality (see Figure 2, below). Most of the time, discussion about quality will be high level and strategic, but there will be times when the board needs to examine the detail – for example, to get a snapshot of patients' experiences, to discuss compliance with the hygiene code or data about serious incidents.

Figure 2 Managing the levels of conversation about quality



It is around these 'snapshots' that non-executives are likely to be uncertain over how far to probe. The nurse executive can help non-executives navigate this with their executive colleagues, knitting together the detailed snapshot with the strategic goals of the organisation to create a fuller, richer picture. Relationships of conversation need to be in the right order for boards to have this discussion, as Figure 3, overleaf, illustrates.

Figure 3 Relationships of conversation

Facilitating clinical engagement and collaboration

Another critical success factor for nurse executives is their ability, as leaders of the largest part of the health workforce, to harness the support and co-operation of clinical colleagues. As was the case during the pilot phase of the programme, the nurse executive's key alliance was with the medical director. Together, these executive clinicians need to exploit their power to serve as a conscience for the board.

We heard a number of examples of successful integrated working between nurse executives and their medical directors, but this was only in a minority of the sites studied. For example, at one site, the nurse executive shared responsibility for the clinical agenda with the medical director. They had worked together successfully around infection control and were planning to produce joint strategies for the board. We observed nurse executives and medical directors working together as a team at board meetings, demonstrating how clinicians can work together collaboratively, which should bring benefits in influencing the culture of the broader clinical team. But there is still some way to go in getting the nurse executive and medical director to share the burden of leading the quality agenda; at the sites we visited, the nurse executives appeared to be doing much of the work.

Securing better engagement of frontline clinicians is a key task for the nurse executive and medical director to collaborate on. A strong theme to emerge from the second phase of the programme was the need to strengthen clinical engagement with the board and the potential gains for clinical quality. At a fundamental level, boards need to demonstrate that they are 'in touch' with frontline clinicians, and to reinforce that patient care is important to the board.

Clinical engagement is also about creating opportunities for mutual education – helping clinicians understand what the board does, and vice versa (this is particularly important where a board does not do a lot of walking the wards). This mutual understanding should reap rewards for quality assessment in terms of illuminating areas of clinical risk where information is lacking. Linking the views and experiences of staff to feedback from patients should also provide boards with invaluable intelligence for quality assessment. In terms of quality assurance, boards rely on clinicians engaging in clinical governance

processes to ensure that the right mechanisms are in place to assess quality and secure improvements in services. At one site in particular, there was a perception among the top team that engagement of clinicians in both clinical governance and clinical leadership needed to be strengthened.

Clinical engagement should also harness clinical ownership of initiatives designed to measure outcomes and improve the patient experience. At one site, the board was pushing ahead with plans to address poor performance in an area of clinical care without engaging the clinicians within the department experiencing the problems. Unsurprisingly, the approach agreed by the board was unsuccessful. This demonstrates how frontline clinicians can help to determine what will work and what won't, and the power they have to stop improvement from happening.

A number of factors influence the ability of nurse executives to facilitate clinical engagement with the board. While some nurse executives consider engaging clinical leaders to be the main focus of their job, others feel impeded by a lack of line management responsibility. The ability to influence nursing leaders will be stronger where the nurse executive has this responsibility, enabling them to incorporate quality data in senior nurse appraisal and recognition schemes (such as 'ward of the year'), for example.

Boards have been criticised for appearing 'insulated' from concerns by nursing staff about poor patient care on general wards (Healthcare Commission 2008b). There is clearly a role for nurse executives in representing concerns about clinical care to the board. However, this task is not without risks. On the one hand, nurse executives are well placed to secure exposure for nurses and their work at board level. On the other, there is a question over how far nurse executives should be advocates for nursing staff, and whether this could compromise their ability to provide assurances to the board that nursing staff are delivering high-quality care for patients. As previously mentioned, it is important that nurse executives broaden their focus beyond nursing so that they are not stereotyped (and therefore easily ignored) as the 'bleeding heart' of the boardroom. This highlights the role of the nurse executive as tactician – ie, it may be necessary to lose some battles in order to win the war.

Much relies on how nurse executives relate to senior nursing staff, as well as other clinicians. The nurse executive at one site did a nursing shift once a month and expected those in her direct nursing team to do the same. This nurse executive met the matrons every fortnight, at the same time as the medical director met with clinical directors. Neither executive clinician had line management responsibility for the lead clinicians. The key test is how nurse executives use the information they have gleaned from engagement with clinicians to influence boardroom debate about quality. We observed that where nurse executives spent comparatively little time with nursing staff, they were more likely to take a reactive approach to clinical engagement. The best nurse executives are out and about on the wards, continually getting feedback from staff and patients, and using this to inform boardroom discussions.

Helping boards to scrutinise data on quality

Evidence from the Healthcare Commission (2009b) suggests that boards are more likely to fail where they do not receive adequate information about the quality of care provided by their organisations. Even where information is collected routinely, it may not be used to inform decisions and can provide 'false assurance' to boards (Healthcare Commission 2008b). Acute trusts, and in particular foundation trusts, tend to be more advanced in terms of reporting due to better information systems and a culture of collecting and acting on information (Healthcare Commission 2008a). Failings at Mid

Staffordshire NHS Foundation Trust highlight the dangers of misinterpreting available data (Healthcare Commission 2009a).

The first phase of our programme revealed a great deal of uncertainty over the types of clinical information boards need to receive. We concluded that boards need a balance between different types of clinical information, and identified principles that underpin good-quality data (*see box below*).

During the second phase of the programme, we observed that reporting about clinical quality is stronger and that boards are more determinedly moving in the right direction. This probably reflects Lord Darzi's *NHS Next Stage Review* (Department of Health 2008a) and a more distinct quality agenda, combined with a clear business imperative in the form of quality accounts. These will increase boards' attention to quality improvement and increase public accountability on quality; however, a number of issues need further attention. The King's Fund has welcomed the emphasis on board ownership of quality reports. Yet the process of approving a quality report is new, and some boards may require specific support to challenge aspects of the reports and develop their sense of 'ownership' of the quality issue (King's Fund 2009). In preparing for quality accounts, our observations suggest that boards also need to confront the considerable anxiety around interpreting data on quality.

Principles that underpin good information on clinical quality

1. Quantitative data, including metrics and trends, with narrative that interprets the data and draws on 'soft intelligence' such as patients' stories.
2. Succinct presentations that focus on one area, issue or service at a time.
3. Consistency in presentation and format of clinical information.
4. A transparent process for identifying new priorities.
5. A regular, protected slot on the agenda, which allows sufficient time for discussion.

Nurse executives need the skills to be able to analyse, interpret and present quantitative data, and also to present narrative about the patient experience that adds a more personal dimension to care.

Source: Machell *et al* 2009

Anxieties mainly centred around a need for better information (and some concern that the infrastructure is still not in place to deliver important data), for better use to be made of data, and for a greater focus on clinical outcomes. The introduction of patient-reported outcome measures (PROMs) should help boards to understand outcomes from the perspective of patients. However, their ability to illuminate quality is currently limited by the four surgical conditions being measured, some of which have long been associated with uncertainty over their benefit to patients' quality of life.

One nurse executive identified a number of areas of significant clinical risk where she perceived data to be lacking. These were: deteriorating patients on general wards; slow implementation of early warning security systems; the reporting of medication incidents; and nursing documentation. If nurse executives were all asked to identify areas of poor data, this list would very likely grow. It reflects difficulty pinning down what good-quality care looks like and what the top indicators of clinical quality should be. Nursing care indicators go some way in this respect (for example, the Blackpool Nursing Care Indicators look at falls assessment, nutrition, pain management, pressure area care,

medicine administration, observations and infection prevention), but boards appear to spend little time thinking about what indicators for quality they need. Nurse executives are in a good position to engage clinicians (doctors, nurses and others providing clinical care) in leading work to identify the right metrics for clinical quality.

Griffiths *et al* (2008) reviewed ‘state of the art’ nursing quality metrics. They highlighted the following among the most widely used indicators: safety measures such as failure to rescue (death among patients with treatable complications); falls; healthcare-associated infection; and pressure ulcers. Neither effectiveness (defined as positive contributions to well-being) nor compassion (elements of patient experience) were strongly represented in the existing measures.

The Audit Commission (2009a) has found that very few trusts have comprehensive assurance processes in place for data quality and found limited evidence of formally planned audit or review programmes to verify the accuracy of data reported. This reinforces the idea that there is a lot of confusion among board members about the purpose of data around quality that is collected, and anxiety over how to interpret and use that data. The Commission recommends that boards develop policies on data quality and assurance processes, including allocating responsibility for data quality. Boards can also assess themselves against the standards for better data quality defined by the Audit Commission (2009b).

The sites we observed were drawing on a range of information, from the *Essence of Care* benchmarks (NHS Modernisation Agency 2003) and patient surveys, to infection control information and data generated by Dr Foster and Caspe Healthcare Knowledge Systems (CHKS) – both sources of health intelligence. One nurse executive described the information she used to assure herself about clinical quality (rates of infection, pressure sore prevalence measurement, exit cards to capture the patient experience at ward level, complaints and serious incidents, ‘essence of care’ system, and the national patient survey). But it was unclear how much of this information was systematically presented to the board, and what role the nurse executive played in doing this.

It is difficult to pin down precisely what impact information has on boards. We observed boards where data for quality assessment and quality assurance was used effectively, but little use was made of information for quality improvement. We observed a good example of how judicious use of information can really engage boards in quality issues, in the form of a presentation by one nurse executive about compliance with nursing care indicators. The dashboard she presented was a sea of red and profoundly shocked her executive colleagues. However, it led the board to discuss the work that was needed to improve the situation. This nurse executive also used data to good effect by measuring quality performance at ward, directorate and board level, and by linking patient survey data with staff survey data.

Integrating different sets of data in this way can enable assessment of quality from different perspectives, as well as validating the findings from one dataset. Assurances to the board could be strengthened further still by integrating a number of different sources of information – for example, analysis of nursing care indicators with staff surveys, information from safety walkabouts, governors’ feedback, and inspections by the Care Quality Commission (CQC). Linking datasets in this way can help boards to understand the full picture when it comes to quality improvement.

However, most organisations do not adopt this approach, not least because greater priority tends to be given to quantitative data rather than patients’ stories and other qualitative information. We observed that boards tend to reserve close questioning for data perceived to be more objective (such as finance), which may suggest a lack of confidence with interpreting other types of information. There would also appear to be

uncertainty about what constitutes evidence. NHS organisations have developed formal systems of reporting, but often neglect the importance of informal, qualitative data – such as patients’ stories – in triangulating other fragmented data. Consequently, boards tend to be poor at closing the feedback loop by interrogating patients’ stories that may give a different dimension to quantitative data. There is a role for nurse executives to play in developing their boards’ capabilities to access informal, qualitative data and to regard it as no less valid than quantitative data.

Reinertsen *et al* (2008) neatly sum up the value of bringing patients’ stories into the boardroom: ‘When they hear stories of the patients and families whose lives have been affected by quality and safety events, boards will drive for improvement with a much greater sense of urgency and commitment.’ However, the purpose of doing this needs to be made explicit. One site we observed regularly set aside half an hour at board meetings for patients to discuss complaints and their experiences of care. However, a lack of clarity about the purpose of this activity undermined its value, leaving it unclear whether it was for quality assessment or simply a customer satisfaction exercise. There was a danger that the stories of real patients served as distraction therapy for the board and to assuage high levels of anxiety. Successful boards will use patients’ stories to improve care by being explicit about the link between anecdotes and the organisation’s strategy for quality improvement.

Nurse executives also have an important role to play in interpreting the narrative about the patient experience and articulating the learning that arises from that narrative. Effective qualitative data techniques can transform an individual patient story or event into a tentative theory about what may be going on, which can be triangulated with other data and close the feedback loop. Successful nurse executives know how to use a patient story to raise the strategy ceiling on board conversations (*see* Section 1) and to manage the reaction that other board members, particularly non-executives, may have to the story.

Key messages

- The most successful nurse executives are skilled facilitators who are able to help non-executive and executive colleagues understand and scrutinise data on clinical quality.
- Nurse executives need to operate tactically – knowing when to intervene, and when to raise strong concerns about a particular issue.
- There is uncertainty among non-executives and executives over what a legitimate level of enquiry for non-executives is, and how they can most effectively fulfil their quality assurance role.
- Nurse executives have a key role to play in strengthening board engagement with frontline clinicians. However, they should be mindful of the risks attached to adopting an advocacy role for nursing staff in the boardroom.
- Nurse executives are well placed to engage clinicians to lead the development of metrics for measuring high-quality care.
- Boards could strengthen their quality assurance role by integrating different sources of data, including qualitative information such as patients’ stories as well as quantitative data.

Coaching points for nurse executives

What knowledge do you need to offer your non-executives to help them become more effective?

What questions should non-executives be asking in relation to clinical quality?

How can you best create an environment that is conducive to discussing issues of clinical quality?

What preparation would help the non-executives (eg, background reading or a briefing on the issue to be discussed)?

How can you plan and prepare for board meetings in a way that will enable you to bring quality issues alive?

What behaviour do you adopt with clinical colleagues and other executives?

How well placed are you to voice concerns from nursing staff about clinical quality in the boardroom?

How could you help your board make the best use of different types of data on clinical quality?

4 Summing up

Clinical quality occupies a fragile position in many NHS boardrooms. This report has looked at how NHS boards can make continuous quality improvement their top priority. Sustaining this focus is as much to do with issues of leadership, culture and process, as it is to do with finding ways to embed the quality agenda.

Practical ways to strengthen a boardroom focus on clinical quality include: linking clinical issues with others aspects of the business, such as financial efficiency; developing the capabilities of board members around interpretation of data and quality improvement approaches; and putting the right structures in place, such as a quality strategy to support ongoing engagement with clinical quality.

Nurse executives are well placed to serve as internal change agents in this respect. The most successful nurse executives are skilled facilitators who can help their colleagues understand and scrutinise quality data, who can integrate quality with other areas of core business, and who can strengthen board-level engagement with frontline clinicians. We have observed nurse executives giving their board a wake-up call in relation to clinical failings by communicating the patient experience, and helping the board to manage its response. Nurse executives need to demonstrate their worth, and boards need to value their nurse executive.

Two key factors distinguish the pilot phase from this second phase of the programme. The first is the external environment and the emphasis within health policy on the quality agenda, which is unlikely to abate even through the financial storm that faces the NHS over the coming years. The second is the appetite that NHS boards have demonstrated for practical guidance on how to embed mechanisms for quality improvement at all levels of their organisation.

What remains unchanged is that boards need to have the right building blocks in place to sustain their focus and interventions on quality: the right information; the right relationships and governance arrangements; and strong clinical leadership and clinician engagement. Also unchanged is the importance of the leadership demonstrated by chairs and chief executives around the quality agenda, and the culture that these two individuals help to set for the board and the rest of the organisation. The ability of executives and non-executives to challenge their board colleagues also remains of fundamental importance – asking ‘why’ questions is the only way to really find out what is happening with quality issues.

There are some areas where we need to learn more. These include the performance of sub-committees in scrutinising data for quality, the flows of information from these structures to the board, and their impact on the ability of the whole board to engage with quality issues. There is also some way to go to fully understand the dataset that boards need to enable them to scrutinise for quality assessment, quality assurance and quality improvement. Knowing what data are the right data is the biggest area of uncertainty for boards.

Ten things that boards can do

We have set out below ten things that boards can do to sustain engagement with quality improvement in the longer term.

1. Set the context for engaging in quality – be clear about what it means for your organisation, define its relevance to different aspects of the business, and be prepared for the fact that engaging with quality may at times be an uncomfortable experience.
2. Shape the culture and tone of your organisation so that clinical quality becomes the top priority – the board needs to adopt the right behaviours and leadership style, and communicate the value it places on quality to managers and staff, patients and families.
3. Develop a strategy for quality improvement (*see* Appendix B for guidance on this) or, at the very least, make explicit commitments in relation to quality (for example, to increase the organisation's scores in terms of the quality elements of the Annual Health Check).
4. Have a dedicated quality sub-committee of the board to oversee quality assessment, quality improvement and quality assurance, and to provide assurances to the board that these tasks are being fulfilled effectively.
5. Pay attention to dynamic administration, including the length of meetings, the volume of papers, and appropriate breaks. If the basics are not right, the board will not be in a position to give its full attention to quality.
6. Review the use of sub-committees and ensure that the correct breadth and depth of information regularly reaches the board.
7. Put quality at the top of the agenda for board meetings and devote at least 25 per cent of time to discussing quality issues.
8. Draw on a mix of both qualitative and quantitative data to form a rich picture of the quality of care being provided by your organisation, including using patient stories and information from ward 'walkabouts'.
9. Make good use of clinical executives on the board and clinical leaders throughout the organisation to drive the quality agenda.
10. Develop the board's capability to understand and promote quality improvement – non-executives in particular may need support to do this, but also executive directors who do not have a clinical background. This may require building knowledge and skills in quality improvement approaches, quality assurance systems and skilling up in data analysis.

Theoretical underpinnings of the programme

Organisational development

Warren Bennis describes organisational development as a complex strategy intended to change the beliefs, attitudes, values and structures of organisations so that they can adapt to the external environment and the challenges it presents (Warner Burke *et al* 2008). It is a particular kind of change process designed to bring about particular end results. It involves organisational reflection, system improvement, planning and self-analysis. The objective is to improve the organisation's capacity to handle its internal and external functioning and relationships, including things like improved interpersonal and group processes, more effective communication and decision-making processes, more appropriate leadership style, improved skill in dealing with conflicts, and higher levels of trust and co-operation among members of the organisation.

Many of these ideas are drawn from complexity science, theories of human systems and an understanding of the importance of social relationships and connections in motivating people and managing the spread and sustainability of reform (see Matlow *et al* 2006; McDaniel *et al* 2003; Begun *et al* 2003; Zimmerman *et al* 1998; Plsek and Greenhalgh 2001; McDaniel and Dreibe 2001). Numerous high-profile leadership development programmes have been built around these ideas, including The King's Fund's Top Manager programme (www.kingsfund.org.uk/learn/leadership/open_programmes/top_manager.html) and Board Leadership programme (www.kingsfund.org.uk/learn/leadership/blp/).

The emphasis of leadership development and change management has been on changing the way people relate to each other and enhancing capabilities for organisational learning through developing autonomy and creativity, networks and connections, collaboration and partnership, building trust and openness, and sharing power and influence. Wendell L French and Cecil Bell (1973) define organisation development as 'organisation improvement through action research'. Richard Johnson (1976) describes action research as problem-centred, client-centred and action-oriented. Data are fed back in open sessions, and the client and the 'change agent' collaborate in identifying and ranking specific problems, in devising methods for identifying their causes, and in developing plans for coping with them practically.

The 'From Ward to Board' programme has two types of change agents. As consultants, we have served as external change agents, prompting new behaviours within these complex adaptive systems – that is, to get board members to mutually adjust their behaviour, or self-organise, and adapt to the changing internal and external demands.

Just as Johnson refers to feedback in open sessions, our programme is underpinned by an emphasis on real-time working with boards to introduce change. We have observed board meetings and given feedback to board members on their discussion and processes. As external change agents, we have drawn on the grounding in the behavioural sciences and knowledge of systems theory, and used intervention techniques to get board members involved in solving their own problems. Our theory of change is that a good

knowledge base and the right data need to be combined with organisational development and behavioural work in order to secure real change (see Figure A1 below).

Based on these observations, we have conducted coaching sessions with nurse executives to help them boost their impact and effectiveness both within and beyond the boardroom. This has included helping nurse executives to become internal change agents, particularly helping them to think about how their interventions can have more impact and how they can stop themselves being silenced or prevented from intervening.

Figure A1 Theory of change



The action research model and group dynamics approach was developed by Lewin (1958), who was concerned with effecting permanent social change and believed that the motivation to change was strongly related to action: if people are involved in decisions that affect them, they are more likely to act differently.

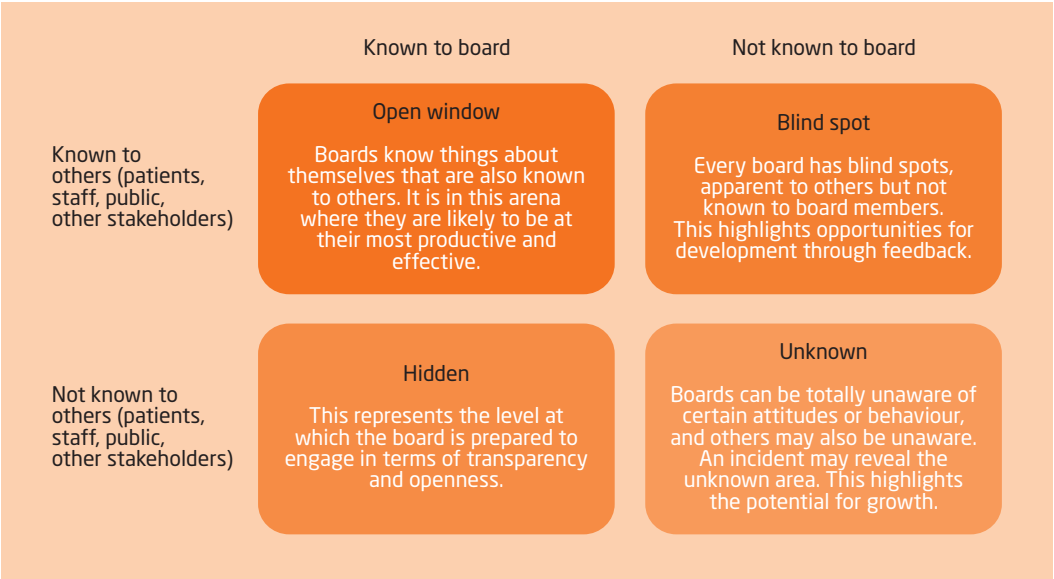
This thinking feeds into later ideas stemming from complexity theory, which are well documented in the physical (Prigogine 1997) and biological (Capra 1996) sciences. Increasingly, these ideas have been applied in health care (McDaniel and Dreibe 2001), and deepened our understanding of health care organisations as complex adaptive systems capable of undergoing spontaneous self-organisation. Acknowledging this, managers can begin to influence this process to facilitate better outcomes. Self-organisation depends on three key system parameters: the nature of connections between people; the rate of information flow through the system; and diversity of ideas and ways of seeing the world (Stacey 1996). Where these system parameters are highly refined, conditions start to exist that allow effective behaviours to emerge. These conditions:

... allow people to create and recreate meaning of events; provide opportunities for higher order learning that changes beliefs as opposed to simply knowing facts or rules; allow creativity; provide positive feedback (feedback that moves a system away from its present position); and provide opportunities for reflection and evaluation of performance.

(Anderson *et al* 2003, p 13)

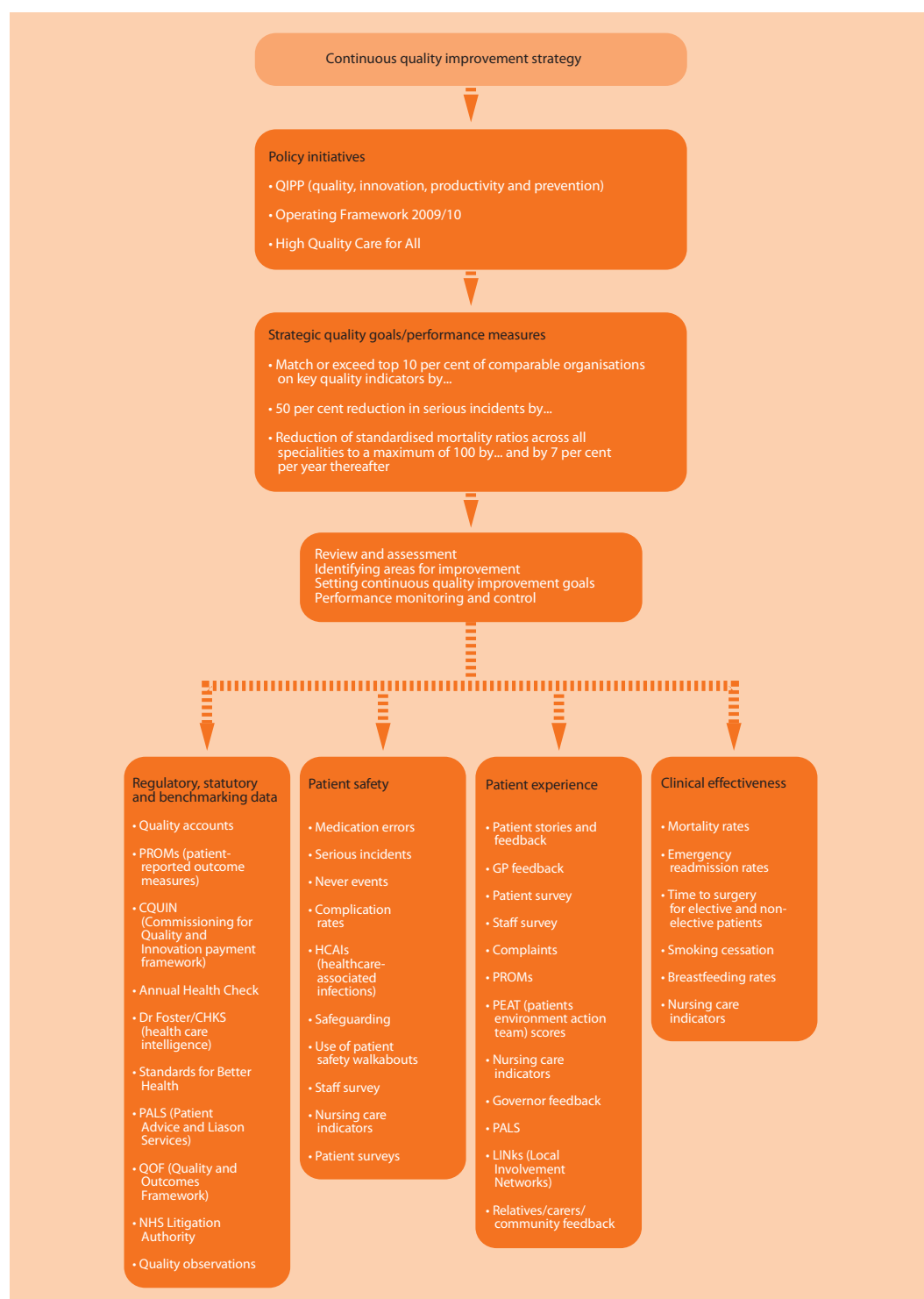
A further theoretical model that has been useful to us in setting out our thinking has been the Johari window, developed by Joseph Luft and Harry Ingram in the 1950s (Luft 1982) (see Figure A2 overleaf). The four windows shown in the model demonstrate different levels of awareness of behaviour, feelings, intentions and motivations, and who knows about these. The 'From Ward to Board' programme has operated across the four quadrants using both disclosure and feedback to illuminate board processes and performance.

Figure A2 The Johari window



Developing a quality improvement strategy

Figure B1 Continuous quality improvement strategy



Enablers

- Establishing 'quality first' culture
- Clinical leadership development and engagement
- Use of NSFs (National Service Frameworks), NICE (National Institute for Health and Clinical Excellence) guidance and evidence-based practice
- Use of improvement methodologies
- Use of 'how to' guides
- Following the National Patient Safety Agency 'Patient Safety First' campaign
- Use of CHKS or Dr Foster data for analysis and triangulation of data
- Collaborative relationships between nurse executive and medical director
- Staffing levels, turnover and sickness/absence rates

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