Taking safety on board: the board's role in patient safety

Adrienne Fresko and Sue Rubenstein

In this thought paper, Adrienne Fresko and Sue Rubenstein look at patient safety advice for boards from recently published guidance and research. They identify the most important messages and the actions they believe board members should take to ensure patients are safe in their organisation. The paper looks at three main areas: the board's core roles in relation to patient safety; how boards might deliver these roles; and the optimal relationship between board leadership, clinical leadership and regulatory oversight. The authors argue that, while the 'safety buck' stops with the board, an effective board should direct its efforts towards building organisational commitment and learning, rather than driving compliance.

Thought paper

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About the authors

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Adrienne is a director and co-founder of Foresight Partnership. She has a depth and breadth of expertise in the development of governance and board effectiveness in public services, as well as a special interest in leadership development and executive coaching.

Adrienne has led the development of highly respected national guidance for boards in public services. This has included guidance for all NHS Boards in England, and its successor, *The Healthy NHS Board 2013*. Adrienne was co-secretary, leading the development and publication of the Good Governance Standard for Public Services.

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She developed *The Healthy NHS Board 2013* – new guidance for all NHS Boards in England – and co-wrote a discussion paper on the governance of clinical commissioning groups.

In her previous role at the NHS Modernisation Agency she led improvement interventions in NHS organisations and systems deemed to be 'failing'. Prior to this, as a Senior Fellow at the Office for Public Management she offered organisational development support across a wide spectrum of public services.

Sue's early career was spent supporting change in public policy in South Africa. Before the first democratic elections in 1994, she supported the broad-based institution that crafted the new housing policy.

Sue is currently a Non-Executive Director of Whittington Health (an integrated care organisation and aspiring foundation trust), where she is the Senior Independent Director and chairs the Quality Committee. She was previously a Non-Executive Director at a primary care trust, served on the board of a housing association and was a school governor.

1 Introduction

Dramatic and tragic failures in patient safety in a small number of healthcare organisations in the UK have meant that patient safety in healthcare has quite rightly been put into the public spotlight. With this, there is a recognition that the 'patient safety buck' stops with the boards of healthcare organisations.

In light of this, there has been a steady stream of advice, exhortation and instruction to boards about their responsibilities in relation to patient safety. But making sense of this range of guidance and research can be challenging.

We have spent many years working in the areas of governance and board effectiveness, and are able to draw on this experience to sift through the available guidance and identify pertinent advice for board members.

For this paper, we have selected what we feel are the best of the most recent sources of guidance and research on patient safety. We have referred to these as 'the sources' throughout this paper. The main sources are:

- Vincent C, Burnett S, Carthey J. *The measurement and monitoring of safety: drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring*. The Health Foundation; April 2013.[1]
- The QUASER team. *The QUASER guide for hospitals: a research-based tool to reflect on and develop your quality improvement strategies*. London: UCL; 2013.[2]

- *A promise to learn – a commitment to act: improving the safety of patients in England*. National Advisory Group on the Safety of Patients in England, chaired by Professor Don Berwick, August 2013.[3]

We have also used the guidance we developed for NHS boards in England, *The Healthy NHS Board 2013,*[4] as a framework to help boards interpret and make active use of the advice in the sources. As we considered the key messages from each of these documents, we were struck by how consistent and resonant their messages and learning seemed to be.

This paper is organised into three main sections:
1. What are the board's core roles in relation to patient safety?
2. How might boards deliver these roles?
3. What is the optimal relationship between board leadership, clinical leadership and regulatory oversight?

Our thanks go to the Health Foundation for encouraging us to write this paper. We hope that our suggestions about how boards can improve patient safety in their organisations will be of value to NHS board members across the UK.

2 What are the board's core roles in relation to patient safety?
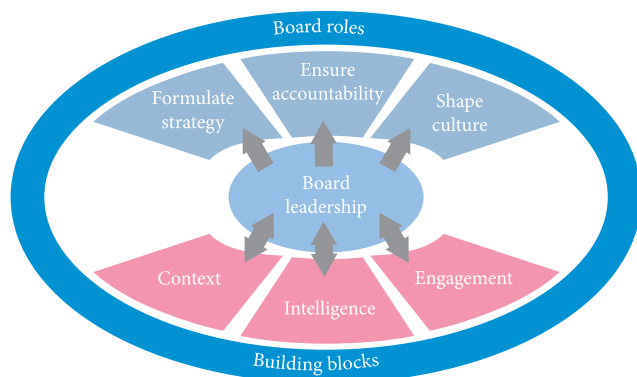
First and foremost, effective boards demonstrate **leadership** of the organisation they are accountable for, and in relation to the wider health and social care context within which they are operating. The Berwick report describes leadership as:

'about mobilising the attention, resources and practices of others towards particular goals, values or outcomes'.[3] The report also sets out boards' leadership responsibilities for patient safety:

> *All leaders concerned with NHS healthcare… should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.[3]*

The framework we developed in *The Healthy NHS Board* (see Figure 1),[4] suggests that boards have three core roles in relation to patient safety: formulating strategy, ensuring accountability and shaping culture. We discuss each of these roles in more detail below.

Figure 1: Board leadership: roles and building blocks[4]

Formulating strategy

The first core role of the board is formulating strategy for the organisation.[4] The consistent message across all sources used for this paper is that an effective

strategy needs to include a clear vision and purpose for the future that puts quality of care and the safety of patients at its heart.

To achieve this, firstly, boards should provide clear strategic direction for their organisations to enable them to meet quality improvement challenges. This quality strategy should provide a framework for a safe service and set out the organisation's strategic aims for patient safety[3], including safety ambitions such as zero harm and 100% reliability of care delivery[1]. Asking the question 'Will care be safe in the future?'[1] could help ensure that the strategy is appropriately focused.

Secondly, boards should focus on building the capacity and capability within their organisation to make use of safety improvement methods, for example human reliability analysis and safety cases.[1] Thirdly, boards should be encouraged to demonstrate awareness of the broader contextual factors (social, political, economic) that influence their organisation, and devise strategies to proactively manage them.[2]

Ensuring accountability

The second core role of the board is ensuring accountability.[4] This has three main aspects:

- holding the organisation to account for the delivery of the quality strategy
- seeking assurance that the systems of control are robust and reliable
- being accountable for the organisation operating effectively and with openness, transparency and candour.

Where boards are unitary, all directors are collectively and corporately accountable for organisational performance. Developing informed approaches to accountability in relation to patient safety is a central responsibility of the board. This is reinforced in the Berwick report, which sets out the expectation that healthcare organisations: 'regularly review data and actions on quality, patient safety and continual improvement at their Board or leadership meetings'.[3]

Quality governance and risk management are central to the board's role in patient safety, and NHS organisations now have a statutory duty to secure continuous improvement of quality. To help them fulfil this duty, the board should give robust, systematic and consistent attention to effectiveness and outcomes, patient safety and patient experience.[4]

The measurement and monitoring of safety[1] proposes a framework (see Figure 2) that boards could find useful when thinking about the data and intelligence they will need in order to be assured about patient safety in their organisation. The dimensions of the framework arise from the following five questions:

1. Has patient care been safe in the past?
2. Is care safe today?
3. Are our clinical systems and processes reliable?
4. Are we responding and improving?
5. Will care be safe in the future?

Figure 2: A framework for the measurement and monitoring of safety

To date, board attention on patient safety has often been centred on the first question, ie focusing on past harm. If boards are to really undertake this role of ensuring accountability for the future, we believe they need to focus on all five areas. We have suggested how these questions might be addressed in practice in Figure 3 (see page 9).

For board members to really understand the meaning behind patient safety intelligence, they should look beyond written intelligence alone and develop an understanding of the daily reality for patients and staff, for example through safety walkrounds.[1] This can help make data more meaningful[4] and support the process of triangulation; allowing board members to 'test' the intelligence and seek assurance by looking at more than one source and type of information.[4]

Although risk management approaches are becoming increasingly sophisticated, with risk registers incorporating robust, evidence-based assessments of risk, recent patient safety research has emphasised the importance of including *prospective* risk assessment methods; identifying leading indicators that may point to escalating problems. We suggest boards ensure their organisation's approach to risk management includes these prospective risk assessment methods. Examples of such approaches include human reliability analysis or failure modes and effects analysis.[1]

The board is also accountable for their organisation operating with openness, transparency and candour. This has become more prominent following the second Francis report.[5] To help with this aspect of their role, boards may want to take account of the following advice from both the Berwick report and *The Healthy NHS Board*:

- The Berwick report states that transparency should be 'complete, timely and unequivocal'. It advises that all non-personal data on quality and safety should be shared 'in a timely fashion with all parties who want it, including, in accessible form, with the public'.[3]
- As we advised in *The Healthy NHS Board*, boards should also seek assurance that their organisations are complying with the contractual duty of candour, which requires providers to inform people if they believe treatment or care has caused death or serious injury.[4] To complement this, boards should ensure that there is a clear assurance and escalation framework in place and that there is a whistle blowing policy with support and protection available for bona fide whistle blowers.[4]
- Complaints provide vital information about the quality and safety of care, and should be gathered and responded to in a timely way. We advise leaders of healthcare organisations to look to continually improve their local complaint systems,[3] and directors to personally listen to complaints, concerns and suggestions from patients and staff, and to act on them fairly.[4]

Shaping culture

The third core role of the board is shaping a healthy culture for an organisation. This recognises that good governance flows from a shared ethos or culture, as well as from systems and processes. The board should take the lead in establishing, modelling and promoting values and standards of conduct for the organisation and its staff.[4]

The sources used for this paper emphasise the board's role in creating an organisational culture in which quality is a shared value that is central to clinical work and underlies all aspects of the organisation's activities.[2] Boards are advised to be involved in modelling and exemplifying a 'safety climate', and indeed understanding what the current safety climate is in the organisation, for example through safety culture analysis and safety climate analysis.[1]

It is important that leaders are visible, especially to frontline staff. As the Berwick report states:

Leadership requires presence and visibility. Leaders need first-hand knowledge of the reality of the system at the front line, and they need to learn directly from and remain connected with those for whom they are responsible. Culture change and continual improvement come from what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours.[3]

Another important cultural theme we identified in the sources is the importance of developing a learning culture, rather than a blame culture. For leaders, this means creating and supporting the capability for learning, and therefore change, at scale.[3] This continuous learning process should be 'supported and nurtured' by the organisation.[2]

The final word on culture comes from the Berwick report:

culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime.[3]

3   How might boards deliver these roles?

In this section, we discuss what approaches boards might want to consider in order to deliver these core roles. We have focused on four key aspects: engagement, intelligence, building board capacity and capability, and prioritising a people strategy.

Engagement

Board engagement largely revolves around engagement with patients and staff. However, as the QUASER guide recognises, quality improvement requires the support of all stakeholders and key occupational groups[2] (we will return to clinical engagement in section 4). The Berwick report emphasises that patients and their carers should be 'present, powerful and involved at all levels of healthcare organisations'.[3] It advises that:

- boards and leadership bodies 'employ structures and processes to engage regularly and fully with patients and carers, to understand their perspectives on, and contributions to, patient safety'.[3]

- the patient and carer voice should be seen as 'an essential asset in monitoring the safety and quality of care'.[3]
- feedback is most effective when collected as far as possible in real time and responded to as quickly as possible.[3]

In addition, it is important for boards to listen to the voices of staff, to help monitor the safety and quality of care in each unit. The Berwick report suggests that this can be done through department and ward level cultural and teamwork safety surveys.[3]

Intelligence

Boards need information that is timely, reliable, comprehensive and suitable for board use. However, there is an increasing recognition that paper-based (or even tablet-based) intelligence can only take the board so far. We suggest boards should use a sophisticated blend of soft and hard intelligence.[4]

As well as being assured that the physical and technological requirements are in place to support quality improvement and monitoring,[2] boards also need to ensure that their organisation routinely collects, analyses and responds to early warning signs of safety problems. These include the voices of staff and patients, staffing levels and the reliability of critical processes. As the Berwick report states, these can be 'smoke detectors' and signal problems earlier than mortality rates do.[3]

Board members should also try to understand the variation in quality between departments within their organisation. As well as reporting aggregated data for the whole organisation, data on fundamental standards and other reportable measures, as required by the Care Quality Commission, should be reported by each ward and clinical department within the trust's annual quality account.[3]

As discussed above, *The measurement and monitoring of safety*[1] suggests a framework with five dimensions of intelligence about safety. In Figure 3, we have picked out key points that might be relevant to boards, along with some additional points from other sources.

Building board capacity and capability

It is important that boards and their members, including non-executive directors, understand enough about patient safety to be able to contribute effectively to formulating a quality strategy, ensuring accountability and shaping culture. They should have enough confidence in this area to ask the right questions, to model the right behaviours, and to challenge if there are safety concerns that are not being addressed. They should also develop sufficient understanding of quality improvement methods, such as human reliability analysis, failure modes and effects analysis and root cause analysis.[1]

The Berwick reports suggests that quality and patient safety sciences and practices be part of the 'initial preparation and lifelong education of all healthcare professionals, including managers and executives'.[3] Holding an annual board seminar to look at learning across strands and themes from all safety-related information could be one way to help achieve this.[1]

Figure 3: What safety intelligence should boards ask to see?[1]

Past harm: Has patient care been safe in the past?

Intelligence on past harm could include information about:

- treatment-specific harm, eg adverse drug reactions
- harm due to over-treatment, eg falls as a result of excessive use of sedatives
- general harm from healthcare, eg hospital-acquired infections
- harm due to failure to provide appropriate treatment, eg failure to provide prophylactic antibiotics before surgery
- harm resulting from delayed or inadequate diagnosis, eg misdiagnosis of cancer symptoms
- psychological harm and feeling unsafe, eg clinical depression following mastectomy.

The intelligence should be gathered using measures of harm which are valid and reliable. Mortality rate indicators such as the Hospital Standardised Mortality Rate are one of the ways to detect potentially severe performance defects worth investigating further.[3]

Reliability: Are our clinical systems and processes reliable?

Intelligence to help assure boards that their organisation is working towards 'failure free operation over time' might include results from clinical audits showing monitoring of compliance with guidelines and protocols. For example, rates of compliance with:

- prescribing guidelines
- hand hygiene guidelines
- screening inpatient admissions for methicillin-resistant Staphylococcus aureus (MRSA)
- all elements of the pressure care bundle
- completion of falls risk assessments within 24 hours of admission
- intravenous drug administration guidelines
- the surgical safety checklist.

The focus should not just be on specific points of the care process, but also on a more holistic view of reliability across a clinical system, eg the use of care bundles in critical care.

Sensitivity to operations: Is care safe today?

Intelligence that could assure boards that there is executive attention to sensitivity to operations could include real-time information from safety measurement performance systems, first-hand observations through safety walkrounds, or evidence of executive/clinical approaches including:

- the use of designated patient safety officers
- meetings, handovers and ward rounds
- day-to-day conversations; informal dialogue between healthcare teams and managers
- patient interviews to identify threats to safety.

Anticipation and preparedness: Will care be safe in the future?

Intelligence that could assure boards that care will be safe in the future could include:

- serious incident analysis; reviewing lessons learned from serious incidents
- evidence that reporting systems for serious incidents are used and that appropriate action is taken in response to incidents[3]
- information about the prevailing safety culture in the organisation, such as safety culture analysis, eg the Manchester Patient Safety Framework
- staff indicators, eg sickness absence, training on medication safety, frequency of sharps injuries
- information on staffing levels.

Integration and learning: Are we responding and improving?

Intelligence that could help assure boards that their organisation is learning could include:

- analysis of all safety incidents (and other quality intelligence) to demonstrate trends and patterns
- evidence of learning from incidents through, for example, root cause analysis, looking at patterns and understanding what system weaknesses may still be present.

Many healthcare reporting systems expend the majority of their effort on data collection. However, it may be more effective to instead consider the cycle of: information, analysis, learning, feedback and action.

Prioritising a people strategy

There is a wealth of evidence showing that the key to providing safe, effective and compassionate care to patients is supporting and valuing staff. Staff wellbeing, however, is not just a matter of culture. It depends on tangible elements such as good management, effective job design, education, training and appropriate resources.[6]

A powerful theme that we found emerging from the sources for this paper is the importance of developing and putting into place effective, supportive people strategies. In *The Healthy NHS Board,*[4] we identified five domains that a people strategy should cover (see Figure 4).
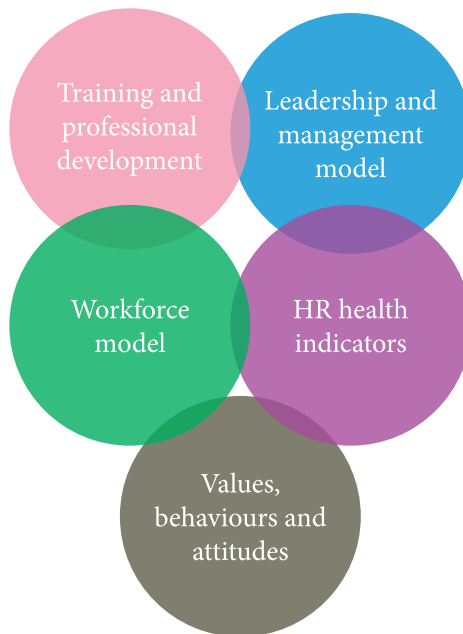
The sources for this paper contain useful contributions to thinking about a 'people strategy'. We have selected some key points from the sources in relation to:

- leadership and management
- the workforce model, including organisation structures, recruitment implications and staffing
- approaches to training, learning and professional development, including performance review.

Leadership and management

It is important that leaders and managers actively support staff. The Berwick report outlines that this can be done through: 'excellent human resource practices, promoting staff health and well-being, cultivating a positive organisational climate, involving staff in decision-making and innovation, providing staff with helpful feedback and recognising good

Figure 4: Elements of a people strategy

performance, addressing systems problems, and making sure that staff feel safe, supported, respected and valued at work'.[3]

The workforce model

Boards and leaders should take responsibility for ensuring that clinical areas are adequately staffed; ensuring that staff are present in 'appropriate numbers to provide safe care at all times and that they are well supported'.[3]

The organisational structure should support ongoing improvement work and include roles, responsibilities, committees, lines of authority and reporting, incentives and rewards. This includes identifying and securing the skills and knowledge required for quality improvement.[2]

It is important that an organisation's 'people strategy' is informed by learning from all safety-related information, eg recruitment standards for nursing staff.[1]

Approaches to training, learning and professional development
Continuous learning processes need to be supported and nurtured by the board,[2] and patient safety should be part of initial and ongoing education of all healthcare professionals.[3]

The Berwick report suggests that priority be given to 'targeted investment in building capability within organisations to enable staff to contribute to improvement of the quality and safety of services to patients'.[3] NHS organisations are also encouraged to participate in one or more collaborative improvement network and make use of peer review outside formal systems – for example by partnering with other organisations – to facilitate learning.[3]

Building on the introduction of medical revalidation, NHS organisations will also need to work with professional regulators to 'create systems for supportively assessing the performance of all clinical staff'.[3]

4   What is the optimal relationship between board leadership, clinical leadership and regulatory oversight?

In this paper, we have sought to draw on the best recent guidance to help boards assure themselves that the right processes are being operated in the right places, by the right people, in the right way, to safeguard patient safety. However, in times of intense public and political scrutiny, the default position can become 'the board has to see this'. Boards can then be deluged by voluminous papers that soak up board member time and can act to obscure and obfuscate, rather than illuminate.

We know that board governance of patient safety is only as effective as the operational/organisational systems for ensuring patient safety on which it rests. This is often referred to as quality governance that goes from 'board to ward' or 'board to floor'. But maintaining clear roles and operating effective interfaces between the board and operational governance of patient safety can be challenging.

Healthcare organisations are, for the most part, structured into clinically-led divisions/directorates with devolved accountability for managing a defined cluster of clinical services. It is, first and foremost, clinical directorates that need to be enabled to take full ownership of the systems and processes that aim to safeguard quality and patient safety.

Centralised 'quality' functions can offer specialist support and expertise, but directorates should operate their own patient safety systems and see the value in them, rather than viewing them as an onerous demand from a remote 'board' with which they need to comply.

As well as boards, we feel that directorates could also benefit from asking themselves the five questions outlined in *The measurement and monitoring of safety* report (see page 5). This could become a routine and valuable part of the management of the directorate, in much the same way as

managing budgets, rotas, staffing and so on. Crucially, these directorate-level quality and patient safety processes need to enable the directorates to arrive at a robust and comprehensive view about 'risk' to patient safety, and to mitigate and manage this risk effectively. This includes accounting to the executive, the quality committee and, ultimately, the board as appropriate.

The quality committee itself can play a crucial role, on behalf of the board, in seeking assurance that the directorate owns and operates robust patient safety systems and processes. By receiving the directorates' views on 'risk to patient safety', the committee can expose the proposed management of risk to deeper scrutiny and challenge than would be possible by the board.

There are interlocking roles and accountability for patient safety between the board, the quality committee, and executive, operational and clinical leaders. It is therefore important that roles, accountabilities, and escalation thresholds and routes are clear at every level. It should be possible to track the identification, management and, where appropriate, escalation of risks to patient safety through the structures and processes in an open and transparent way.

Much of the public debate about accountability for catastrophic failures in patient safety has put the focus on the extent to which organisations can demonstrate their 'compliance' with externally defined standards and regulatory requirements. By extension, there is a risk that board 'assurance' can become overly focused on an internal policing of these standards. But as the Berwick report points out:

…healthcare organisations should shift away from their reliance on external agencies as guarantors of safety and quality and toward proactive assessment and accountability on their own part.[3]

The report by Charles Vincent and colleagues, *The measurement and monitoring of safety*,[1] offers an important and valuable framework that could be used for this 'proactive assessment'.

Conclusion

We started this paper by recognising that the 'safety buck' stops with the board, and this remains true. However, we also know that the success of a healthcare organisation depends on energy, drive and passion for safeguarding quality and patient safety that must be deeply embedded in the organisation. Therefore, to be most effective, boards should ensure that their efforts are directed towards building organisational commitment and learning, rather than driving compliance.

References

1   Vincent C, Burnett S, Carthey J. *The measurement and monitoring of safety: drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring.* The Health Foundation; April 2013. Available at: www.health.org.uk/publications/the-measurement-and-monitoring-of-safety

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5   *The Mid Staffordshire NHS Foundation Trust Pubic Inquiry,* chaired by Sir Robert Francis QC; February 2013.

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