CONSULTATION RESPONSE
Governance reviews

March 2014

About us

The Health Foundation is an independent charity working to improve the quality of healthcare in the UK. We are here to support people working in healthcare practice and policy to make lasting improvements to health services.

We carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change. We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

In this response we:

1. set out our evidence about the role of boards in promoting quality improvement, patient safety and person-centredness
2. make specific recommendations on the governance review process
3. make recommendations about the domain of measurement and specifically how patient safety and person-centred care can be measured by boards.

1. Our evidence on the role of boards in promoting quality improvement, patient safety and person-centredness

We know from our leadership development and improvement programmes and research that hospital boards have an important role to play in ensuring the delivery of safe, high quality, person-centred care.[1,2,3] In summary, our evidence tells us that an effective board will:

- ensure that their organisation possesses the necessary capability to identify and use appropriate improvement approaches[4]

[1] Health Foundation. *Effective leadership development interventions: a position statement*. The Health Foundation, 2009.
[2] Health Foundation. *What's leadership got to do with it? Exploring links between quality improvement and leadership in the NHS – An evaluation of the Health Foundation's leadership programmes*. The Health Foundation, 2011.
[3] Fresko A, Rubenstein S. *Taking safety on board: the board's role in patient safety*. The Health Foundation, 2013.
[4] Fresko A, Rubenstein S. *Taking safety on board: the board's role in patient safety*. The Health Foundation, 2013.

- provide their organisation with a clear strategic direction and leadership that will help them to meet their quality improvement challenges – for example, evaluations of our improvement programmes have highlighted the crucial importance of board support and leadership on patient safety and self-management support in order to drive and sustain change[5,6]
- Foster a culture at every level of their organisation which is conducive to improvement, and is focused on allowing people to learn from past experiences and mistakes, rather than on attributing blame – for instance, recent research by Professor Charles Vincent highlighted the need for patient safety to be taken seriously at every level of an organisation and the role that senior figures need to play in helping to instil such a culture[7]
- hold the organisation to account for the quality of care it provides and ensure that the systems of control and impact measurement are robust and reliable – we have evidence that successful improvement can be influenced by the action taken by board leaders to establish and track quality and safety indicators and develop processes to ensure and improve quality.[8]

2. The governance review process

In view of the pivotal role that boards play in driving and embedding improvement, we agree that regular external reviews of board governance are appropriate and necessary.

This is particularly important in the light of research we commissioned on hospital boards' attitude to quality. This found that, while boards in England do take a close interest in quality of care issues, many boards believe that their trusts are performing better than they actually are in terms of the quality of service they provide.[9] Almost all the board chairs who took part in the research (n=132) reported that their board has, and regularly reviews, a quality dashboard or scorecard. However, 66 per cent of chairs rated their trusts' performance as being better or much better than that of a 'typical' English trust[10] – suggesting that many boards do not have a clear grasp of how their organisations are performing relative to their peers in the rest of the country. This led the researchers to conclude that there is 'still room for improvement' for boards in terms of the attention they pay to key metrics of care relating to their trust.

However, while there may be benefit from an external body undertaking the governance review, it is important that leaders within the organisation are closely involved in the review from a developmental point of view. We know from other external reviews[11] that such outsourcing can limit the capability building opportunities for an organisation. By failing to involve staff and directors directly, there is a risk that the review will have a short-term impact and will not lead to a continuous process of development.

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[5] Health Foundation. *Safer Patients Initiative, Lessons from the first major improvement programme addressing patient safety in the UK*. The Health Foundation, 2011.
[6] Health Foundation. *Sustaining and spreading self-management support: lessons from Co-creating health Phase 2*. The health Foundation, 2013.
[7] Vincent C. et al. *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, 2013.
[8] Øvretveit J. *Leading improvement effectively: Review of research*. The Health Foundation, 2009.
[9] Jha A, Epstein A. A survey of board chairs of English hospitals shows greater attention to quality f care than among their US counterparts. *Health Affairs* 32/4, 677-85, 2013.
[10] The metric in question was the CQC overall quality of care indicator.
[11] Health Foundation. *Using safety cases in industry and healthcare*. The Health Foundation, 2012.

We would also welcome greater clarity on how this review process will interact with the CQC's approach to inspecting organisations. We note from the consultation document that there is a commitment to ensure that the two approaches are complementary but we feel that more information as to how this will work in practice is necessary. For instance, do you expect the governance reviews to be used by CQC as part of their surveillance programme and ultimately in the information they use to rate organisations? And given the concerted effort to reduce the regulatory burden on the NHS, is there information you will acquire from CQC to inform your own assessments of the governance of these trusts?

3. The board governance framework: the domain of measurement

We welcome the inclusion of measurement as one of the four domains for the governance review and the recognition of the importance of providing boards with appropriate, robust and timely information. In this section we will discuss our relevant learning on the measurement of safety before making some recommendations relating to the definition and assessment of person-centred care.

3.1 The measurement of safety

We think that the governance review process should explore how boards interrogate and use the data they receive and what steps they have taken to understand the contexts in which it is generated. There are three particular areas that we believe boards should focus on:

3.1.1 Using information to build up a comprehensive picture of levels of safety

We think that the framework set out by Charles Vincent and colleagues in *The Measurement and monitoring of safety*[12] would help boards to develop a comprehensive picture of levels of safety. The framework includes the following domains of information:

- The measurement of harm: Has patient care been safe in the past?
- Reliability of clinical systems, processes and behaviour: Are our clinical systems and processes reliable?
- Sensitivity to operations: Is care safe today?
- Anticipation and preparedness: Will care be safe in the future?
- Integration and learning: Are we responding and improving?

3.1.2 Improving data literacy

It is important that boards understand what the information is telling them, the limitations of the data and how variations in how data is collected can make comparisons across units difficult. The difficulty of making comparisons across units was highlighted in *Lining up: How harm is measured.*[13] Here, researchers found that intensive care units were collecting data on infection rates in very different ways. Their interpretation of the inclusion and exclusion criteria and the processes used to collect data (by whom, when and from which sources) varied considerably and, was, in many cases, shaped by the particular working practices of each unit. This made it extremely difficult to make any meaningful comparison across units.

[12] Vincent C, et al. *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, 2013.
[13] Health Foundation *Lining up: How harm is measured? Lessons from an ethnographic research study of interventions to reduce central line infections*. The Health Foundation, 2013.

3.1.3 Combining data with experience

In terms of sources of safety information, Fresko and Rubenstein[14] highlight the importance of looking beyond written intelligence alone and developing 'an understanding of the daily reality for patients and staff'. Safety walkrounds, for example, and other processes that allow board members to hear 'the voices of staff and patients' will help to give boards a richer and more nuanced understanding of how care is being delivered in their trust.

These lessons highlight the complexity of measurement and that it is in effect a social process. It is important that the governance review process reflects this complexity and considers how boards use and understand information.

3.2 The definition and assessment of person-centred care

The good practice examples in the consultation document relating to question eight on the analysis of information on organisational and operational performance (page 36) include one on the need for boards to be given assurance that patients are receiving 'person centred coordinated care'.

While we welcome the inclusion of this example, we feel that boards need more guidance on how to assure themselves that their organisation is genuinely person-centred. The measures needed to assess their organisation's person-centredness are also likely to differ depending on whether care is delivered in an inpatient or outpatient setting.

To assist boards and bring greater clarity to this area, we would suggest the following wording is used on page 36:

> "Board reporting should be able to demonstrate that person-centred care is offered across all of the activities of the organisation"

In relation to inpatients, we believe boards should be able to demonstrate that:

- all patients are treated with dignity and respect (appropriate experience measures would be required)
- at 'decision cross-roads', patients are also supported to share in the decision making process (appropriate involvement measures would be required)
- patients' care is co-ordinated by a named individual (appropriate systems measures would be required).

In relation to outpatients, we would suggest that boards should be able to demonstrate that:

- all patients are treated with dignity and respect
- at 'decision cross-roads', patients are supported to share in the decision making process
- for people who live with long-term conditions, particular attention is given to care co-ordination and care transitions

We feel that this additional explanation will help to ensure that an appropriate level of attention is paid to person-centred care in the governance review process.

[14] Fresko A, Rubenstein S. *Taking safety on board: the board's role in patient safety*. The Health Foundation, 2013.

4. Conclusion

Given the significant role boards play in driving and embedding improvement in care we agree that there needs to be a robust system for reviewing board governance.

We think that board members and other staff need to be closely involved in the review process. This will help to build capability, ensure that findings are meaningful to the organisation and have a resonance beyond the lifetime of the review.

We would also suggest that close attention needs to be paid in the review to how data and other intelligence about safety and quality is interrogated and used by boards. It is crucial to ensure that boards have the skills necessary to interpret data effectively and appreciate its limitations and are not reliant on written intelligence alone.

Finally, we think the way person-centred care is defined needs revisiting. The review process provides an important opportunity to assess to person-centredness of the care being delivered by each organisation, so we need to ensure that the associated review guidance provides a clear explanation of the areas on which boards need to focus.

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