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Health Service Executive
Quality Improvement Division



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Patient Safety 1 First

'Board on Board with Quality of Clinical Care'

Quality Improvement Project: Case Study Report

**Mater Misericordiae University Hospital and
Health Service Executive, Quality Improvement Division**

June 2015

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Foreword

High performing hospitals all have one thing in common: effective and active Board engagement which assumes a decisive role in improving delivery of quality care in hospitals. Compelling evidence, supported by research and discerned from national and international inquiries into patient care, suggests that Boards must have capable, committed leadership at both executive and board levels with the requisite in-depth knowledge to perform this role effectively. However, Boards that are focused on quality still require practical guidance in how to lead their hospital's quality agenda.

To address this need, the Quality Improvement Division in the HSE has been working with the Mater Hospital to develop a set of interventions and to trial them with the aim of enhancing the role of the Board in overseeing and contributing to the improvement of the quality of patient care provided at the clinical frontline. The fruits of this important collaboration are evident in this report. The importance of strong Board leadership to drive improvements of care is well established. This is particularly important in the very challenging circumstances in which we are delivering care to patients in Ireland today. Underlying any effort to improve care must be a clear commitment to measuring performance and monitoring that performance in response to the implementation of evidence-based improvement actions.

The Mater Misericordiae University Hospital's CEO and Board of Directors resolved to effectively integrate quality into the routine Board agenda by navigating the transition from a volume-driven to a value-driven focus. The commencement of the Board-on-Board project in 2014 has activated a number of constructive changes to the Board's functioning, including the implementation of a Board of Directors' Quality Dashboard and extended scheduling for quality of care discussions. This project was designed to equip the Board with practical tools and skills to assume greater responsibility for, and strengthen its impact on, the hospital's quality performance.

We would like to thank all the Board members of the Mater Hospital and the CEO Mary Day for their commitment to improvement as shown by their willingness to participate in this important initiative. We would also like to thank the project group led by Ruth Buckley along with Maureen Flynn and Dr Jennifer Martin for the considerable work and support they have given to this process. The learning from this QI project can now form the basis for the development of the role of Boards across our hospital sector.



Mr. Tom Lynch
Chair of the Mater Board of Directors



Dr. Philip Crowley
National Director Quality Improvement

Overview of Steps taken for Board on Board Quality Improvement (QI) Project

AIM: what do we want to achieve?

The Board of Directors, individually and collectively, (i) get a comprehensive picture of the quality of clinical care, (ii) have an understanding of same, and (iii) act to hold the hospital accountable on the quality of clinical care delivered.

MEASURE: how would we know the change was an improvement?

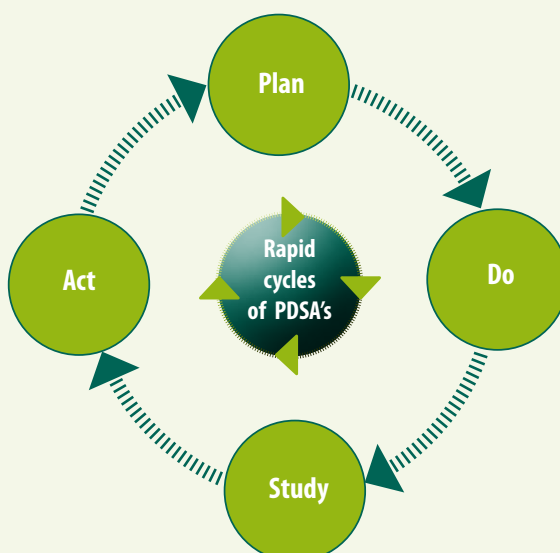
By December 2014, the Board of Directors would have:

- discussed, made assessments and recommendations in response to quality of clinical care indicator (QCCI) information.
- rated the usefulness of the information on quality of care indicators as improved.
- rated their understanding of quality of clinical care indicators as improved.

CHANGE: what changes were made that resulted in improvement?

The Board of Directors:

1. Ten quality of clinical care indicators monitored.
2. Monthly Quality Dashboard and Identify, Situation, Background, Assessment Recommendation (ISBAR) report.
3. ISBAR structure for Board of Directors' discussion.
4. Board of Directors workshop to strengthen understanding of QCCIs.
5. Increased knowledge through targeted monthly reading.



6. International learning with Sir Stephen Moss.
7. Restructured the Board of Director meeting agenda.
8. Restructured the meeting to allow 25% for QCCI discussion.
9. Restructure the meeting minutes to include times, index of Board assessments, decisions and actions.
10. Preparation for quality and safety walk-rounds.

PROJECT GOVERNANCE

1. Agreed project sponsorship (from the Board of Directors and Executive).
2. Prepared board on board QI project charter.
3. Presented and obtained agreement of the Board of Directors to undertake the QI project.
4. Established Board on Board Project Group (inclusive of project lead, key members of staff and Non-Executive Director)
5. Reported progress monthly.
6. Sustained the change- established Phase II Board on Board QI Project.

Project initiation document

- Established the baseline
- Identified change packages
- Agreed the criteria for selecting QCCI

Developed measurement plan

- Delivered ten change packages (individual PDSAs)
- Presented progress and final report to the Board of Directors

Measured Boards level of engagement with QCCI

- Measured feedback from the board of directors by monthly survey
- Revised Quality Dashboard monthly to reflect feedback

Prepared an ISBAR report to accompany each Quality Dashboard

- Continue to review QCCI to meet the priorities of the Board for quality of clinical care.

These are the steps used for this project and are specific to the Board undertaking the project many of the steps overlapped and ran concurrently.

Project Overview

The role of Boards is recognised as having a critical role in safety and quality improvement (Canadian Patient Safety Institute, 2010; Miller *et al.* 2013). Board members, often coming from business, legal or government sectors tend to feel a lack of familiarity around the clinical aspects of quality and patient safety, and may experience apprehension around their contribution to quality and safety efforts at their organisation.

Governing Boards of healthcare organisations are responsible for the performance of their organisations. To achieve their governing responsibilities for quality and safety, Boards can perform various functions: develop a vision around quality and safety improvement for their hospital; define clear and set realistic goals; access, interpret and use valid and appropriate information; monitor performance relevant to these goals; and support initiatives to develop capabilities and foster a culture of quality and safety within the hospital.

This case study report describes a 'Board on Board' Quality Improvement (QI) project method, Board tools developed and tested and the measures used. The tools developed from the QI project enable the Board to deliver on their responsibility to hold the hospital executive accountable for the quality and safety of the care provided. While specific to the context of the one hospital it is anticipated that the tools could be taken and adapted by other Boards for their own particular context.

The Quality and Patient Safety Directorate (now Quality Improvement Division) of the HSE collaborated with the Board of the Mater Misericordiae University Hospital for this quality improvement project. The project sponsors established a hospital project group to design and lead the project on behalf of the Board of Directors'. The HSE sponsored Dr. Jennifer Martin and Ms Maureen Flynn to undertake the Scottish Patient Safety Programme (SPSP) Fellowship and support the project at the Mater. This year long part-time programme provided the fellows with training in methodologies, supervision, and access to international experts, all of which were used to support the Mater Board on Board Project.

This case study report will be of interest to chairs and members of Hospital Boards, along with executive management teams of Hospital Groups and Community Health Care Organisations.

Project aim and objectives

The aim of the 'Mater Board on Board' Quality Improvement (QI) Project (phase one) was for the Board of Directors of Mater Misericordiae University Hospital (MMUH, the Mater), individually and collectively to, (i) get a comprehensive *picture* of the quality of clinical care, (ii) have an *understanding* of same, and (iii) *act* to hold the hospital accountable on the quality of clinical care delivered.

The objectives were that by December 2014, the Board of Directors:

- discuss, makes assessments and recommendations in response to quality of clinical care indicator information
- rate the usefulness of the information on quality of care indicators as improved
- rate their understanding of quality of clinical care indicators as improved.

Project Scope included:

- Determining the Boards' needs and concerns in terms of assurances on the quality of clinical care
- Making proposals / recommendations to the Board based on their feedback
- Ensuring information provided would help with direction and decision making
- Supporting the Board in understanding quality of clinical care
- Changing the process of information being reported to the Board in order to fit their identified requirements
- Improving the communication from the Board on information received.

Project scope excluded:

- Development of new indicators. Due to the timescale of this project, the project used information on quality of clinical care that was already available within the hospital. It is likely that in the future the Board may identify that information on different areas of clinical care are required
- Safety indicators
- Quality in the broader sense
- Extending the project to the Board of Governors or Executive Management Team.

Creating the baseline

Prior to the introduction of change packages, the QI fellows examined the Board's baseline in relation to quality of clinical care through semi-structured interviews with Board members and a review of previous meeting agenda and minutes.

Listening to the voice of the directors

The QI fellows undertook semi-structured interviews to elicit the views of the fourteen members of the Board of Directors' on the picture/information they received on quality of care, the confidence of their understanding of same and the adequacy of time and attention given to quality of clinical care at Board meetings. The themes identified from the interviews guided the approach to the identification of the project change packages.

Review of Mater Board of Directors' meeting agenda and minutes

The agenda and minutes for the monthly meetings from June 2013 to January 2014, were reviewed. This enabled the identification of the position, level of engagement during Board meetings with quality of clinical care, the number of assessments and recommendations made on the quality of clinical care prior to the introduction of change packages.

Change packages

Ten change packages were agreed by the Board for implementation over a ten month period (February to December 2014).

Picture of quality of clinical care

'Picture of quality of clinical care' was defined in this project as the visual and numeric presentation of quality of clinical care information. For data to be useful it must measure aspects of care that are important facets of quality of clinical care and it must do so accurately and in a timely way. The data must also allow for comparison within the organisation over time, to identify improvement or dis-improvement and should allow for comparison with other organisations (benchmarking). The data must be presented in a way that enables timely analysis and interpretation by its users.

A hospital Board of Directors' role is to assure the quality of clinical care across the whole spectrum of services provided by the hospital and to provide leadership and strategic direction to the hospital. Therefore the 'picture of clinical care' that is required by a Board of Directors should be comprehensive, i.e. with a view of a cross section of all important aspects of care, and should be outcomes focused. The detailed and process information that is required to support the executive management of the hospital is not suitable for the purposes of the assurance mandate of the Board, however, the reporting of some process measures at Board level can be requested by the Board.

Tools for Board picture

1. Board of Directors' monitors ten quality of clinical care indicators introduced to the Board on a phased basis. The template with criteria for selection of quality of clinical care indicators can be located in this report toolkit (Resource 2).
2. Board of Directors' receives a monthly Quality Dashboard and report on quality of clinical care indicators. A sample Board of Directors' Quality Dashboard can be located in this report toolkit (Resource 5 and 6).

Understanding of quality of clinical care

'Understanding of quality of clinical care' was defined in this project as the ability to comprehend the indicators in accessing the quality of clinical care. Measurement in the field of healthcare is complex. The Mater Misericordiae Board of Directors, like most Boards, is composed of a mix of executives and non-executives, medical professionals and other professionals. There is no statistician or information expert on board, although a minority of members do have expertise in the measurement of clinical care. Therefore

one of the key aspects of phase one of the Mater Board on Board Project was to identify and deliver training to the Board in order to support them in improving their knowledge and understanding of quality of clinical care indicators.

Tools for Board understanding

3. The Directors understanding of quality of clinical care indicators was strengthened through a workshop designed for Board of Directors. A sample agenda for a Board of Directors Workshop can be located in this report toolkit (Resource 11).
4. The Board of Directors increases their knowledge of best practice in getting Boards on board with quality and safety through targeted reading. The case study reference list includes the monthly Board reading.
5. The Board of Directors shared experience and learned from other Boards approach to quality and safety by meeting with Sir Stephen Moss on the 5th June 2014. Summary learning from the meeting is located in Appendix 2.
6. Non-Executive Directors were invited to participate in quality and safety walk-rounds to hear directly from patients and staff and gain greater understanding of context and environment related to the quality of clinical care indicators being monitored by the Board.

Action for quality of clinical care

'Action' in this project was defined as the Board requesting follow-up/activity of the executive management of the hospital in relation to quality of clinical care information that is presented at the Board meeting. The Board agenda configures the meeting and guides the chair in conducting the business. The chair determines the agenda in consultation with the CEO. It determines what is discussed and the amount of time devoted to discussing the quality of clinical care provided across the Mater Hospital services. The minutes record the discussion, decisions and recommendations made by the Board and are the key record and communication of the Boards' direction to the hospital. Therefore, these documents are useful tools in supporting the Board to prioritise and make recommendations to the Board on actions to improve quality of clinical care.

It is a development of the culture and the acquisition of skills and knowledge that supports the Board to actively question, make assessments and make recommendations to the executive in relation to quality of clinical care.

Tools for Board action

7. The agenda for the Board of Director meeting was restructured to include quality of clinical care indicators. With the aim of this being first or second agenda item (after the minutes/review of recommended actions) for each meeting.
8. The meeting agenda was restructured to allow 25% of the meeting for the quality of clinical care section (verbal reports and dashboard) of the Board meeting. A template agenda for the Board of Directors meeting can be located in this report toolkit (Resource 7).
9. The communication tool ISBAR was used to structure the Board of Directors' discussion of the quality of clinical care indicators (identify, situation, background, assessment and recommendation). The Quality Dashboard ISBAR prompt sheet and guide for writing an ISBAR report for the Board of Directors' Quality, Dashboard can be located in this report toolkit (Resource 3 and 4).
10. The meeting minutes were to be restructured to include meeting times and an index of Board assessments, decisions and actions. A minutes template for the Board of Directors meeting can be located in this report toolkit (Resource 9).

Recommendations

A number of recommendations were made and endorsed by the Board for further development of the Board on Board Project in two further phases of the project (medium and longer term). While specific to the Mater context the recommendations are being shared for other Boards to consider.

*Improve the **information** provided to the Board on quality of clinical care further.*

1. In line with Mater Misericordiae University Hospital Strategic Plan when it is finalised.
2. Keep the quality of clinical care indicators included in the Board of Directors' Quality Dashboard under review to reflect the Board's priorities in terms of quality of clinical care.
3. Develop the Board of Directors' Quality Dashboard further to enable comparisons with peer hospitals.
4. Triangulate information on quality of clinical care by using quantitative indicators together with a range of other sources e.g. case studies and exit interviews/surveys with student health professionals.
5. Improve access to information to enable reporting on indicators.
6. Automate information collection.
7. Expand the Board of Directors' Quality Dashboard to encompass access and finance as well as quality to produce a Board of Directors' Balanced Scorecard.
8. Provide the Board with clinical audit reports.

*Improve **communication and transparency** from the Board directly to clinical staff and the public.*

9. Make the Board minutes available to staff and public.
10. Make the Board of Directors' Quality Dashboard available to staff and public.
11. Consider holding Board meetings in public.
12. Provide defined channels of communication directly between the Board and clinical staff.

***Strengthen governance** of quality and safety further.*

13. Provide an induction programme for new Board members.
14. Progress the establishment of a 'Quality and Safety Board Committee'.
15. Review the Boards' Code of Corporate Governance to include quality of clinical care.
16. Develop terms of reference for the Board of Directors' meetings.
17. In addition to Board of Directors completing a written declaration of interests annually, note at every Board meeting any new relevant conflicts of interest of any member.
18. Provide an ongoing structured development and training programmes for the Board of Directors.

*Improve **patient engagement**, by*

19. Listening to a patient story or case study at each meeting.
20. Consider including patient(s) as members of the Board.
21. Undertaking occasional patient/community meetings.

This project was seen as the start of a journey (phase one), the end point of which is a comprehensive Quality Dashboard used by the Board to hold the executive to account on the quality of clinical care delivered. The process of examining quality of clinical care, using one discrete set of indicators, can be expanded to all indicators and other sources of information on quality of care over time.

Contents

Acknowledgements

Foreword	i
-----------------	----------

Project Overview	iv
-------------------------	-----------

1 Introduction	1
-----------------------	----------

1.1 Background to project	1
1.2 Project aim and objectives	1
1.3 Project sponsors	2
1.4 Project group	2
1.5 Project reports	2

2 Methods	3
------------------	----------

2.1 Project initiation	3
2.2 Ethical mindfulness	3
2.3 Creating the baseline	3
2.3.1 <i>Listening to the voice of the directors</i>	3
2.3.2 <i>Review of meeting agenda and minutes</i>	3
2.4 Change packages	4
2.5 Measuring the changes	4

3 Picture of quality of clinical care	5
--	----------

3.1 Introduction	5
3.2 Ideas from Board of Directors	5
3.3 Literature review and experience from other settings	5
3.4 Changes delivered by this project	6
3.4.1 <i>Quality of clinical care indicators</i>	6
3.4.2 <i>Board of Directors' Quality Dashboard with ISBAR report</i>	7
3.5 Measuring the changes	8
3.6 Next steps	9

4 Understanding	10
------------------------	-----------

4.1 Introduction	10
4.2 Ideas from Board of Directors	10
4.3 Literature review and experience from other settings	10
4.4 Changes delivered by this project	11
4.4.1 <i>Learning from Sir Stephen Moss</i>	11
4.4.2 <i>Targeted monthly reading</i>	12
4.4.3 <i>Board of Directors' Workshop on Quality of Clinical Care Indicators</i>	12
4.5 Measuring the changes	12
4.6 Next steps	13

5	Actions	14
5.1	Introduction	14
5.2	Ideas from Board of Directors	14
5.3	Literature review and experience from other settings	14
5.4	Changes delivered by this project	16
	5.4.1 Restructure Board agenda to include a quality assurance section, early in the agenda, and allocate 25% or more of Board time to this	16
	5.4.2 Use adapted ISBAR tool to structure Board discussion and decisions on quality of clinical care	16
5.5	Measuring the changes	16
5.6	Next steps	21
6	Discussion	22
7	Recommendations	23
7.1	Sustainability	24
8	Conclusion	25
	References	26
	Glossary	27
	Toolkit	29
	Appendix 1: Project initiation document	50
	Appendix 2: Summary report of the visit of Sir Stephen Moss	58
	Appendix 3: Quality and Safety Board Committee	60

1 Introduction

1.1 Background to Project

The quality improvement (QI) project (phase one) arose from a collaboration between the Mater Misericordiae University Hospital (MMUH, 'the Mater'), Quality and Patient Safety Division, HSE (now Quality Improvement Division) and the Scottish Patient Safety Fellowship programme.

The mission statement of the Mater Hospital underpins all activities in the hospital, and this project is specifically supporting the organisation in realising its mission 'to promote excellence and equity, quality and accountability'. The CEO and Board of Directors of MMUH identified QI at all levels of the Mater as a priority (Day, 2014). By undertaking the 'Mater Board on Board' Project, the Board demonstrated their commitment to QI and leading by example, both within the Mater and across the Irish Health System.

This case study report describes the QI project method, Board tools developed and tested and the measures used. While specific to the context of the Mater hospital it is anticipated that the tools could be taken and adapted by other Boards for their own particular context.

1.2 Project aim and objectives

The aim of the project was that the Board of Directors of Mater Misericordiae University Hospital, individually and collectively, (i) get a comprehensive *picture* of the quality of clinical care, (ii) have an *understanding* of same, and (iii) *act* to hold the hospital accountable on the quality of clinical care delivered. The objectives were:

- By December 2014, the Board of Directors prioritises, discusses, makes assessments and recommendations in response to quality of clinical care indicator information
- By December 2014, the Board of Directors rate their understanding of quality of clinical care indicators as improved (by a minimum of one level on a likert scale from one to five)
- By December 2014, the Board of Directors rate the usefulness of the information on quality of care indicators as improved (by a minimum of two levels on a likert scale from one to five).

This project was seen as the start of a journey (phase one), the end point of which was a comprehensive Quality Dashboard used by the Board to hold the executive to account on the quality of clinical care delivered.

Project Scope included:

- Determining the Boards' needs and concerns in terms of assurances on the quality of clinical care
- Making proposals / recommendations to the Board based on their feedback
- Ensuring information provided would help with direction and decision making
- Supporting the Board in understanding quality of clinical care
- Changing the process of information being reported to the Board in order to fit their identified requirements
- Improving the communication from the Board on information received.

Project scope excluded:

- Development of new indicators. Due to the timescale of this project, the project used information on quality of clinical care that was already available within the hospital. It is likely that in the future the Board may identify that information on different areas of clinical care are required
- Safety indicators
- Quality in the broader sense
- Extending the project to the Board of Governors or Executive Management Team.

1.3 Project sponsors

An outline project charter was discussed at the Board of Directors meeting in December 2013 and following confirmation of interest in participating in the project meetings were held with the Chair and Deputy Chair of the Board (January 2014) to scope out and agree direction for the project. The executive leaders and sponsors of the project were the Chief Executive Officer and the Lead Clinical Director (up to May 2014).

1.4 Project group

The project sponsors established a Mater Board on Board project group to develop and lead the project on behalf of the Board of Directors. Membership included a Non-Executive Director of the Board and hospital staff with the key skills necessary to support the project. Additional members were invited to join the group as the quality of clinical care indicators included in the Board of Directors' Quality Dashboard were confirmed.

Table 1: Project Group Membership

Project Lead
Project Manager
Non-Executive Director (representing the Board)
Quality Manager
Risk Manager
Information Analyst/Statistician
Strategy and Service Development Manager
Clinical Governance and Standards Manager
Assistant Director of Nursing - Quality Manager
Administrative Support
Infection Prevention and Control Manager
End of Life Care Coordinator
Falls Prevention Nurse
Scottish Patient Safety Fellows (HSE)

1.5 Project reports

A preliminary report with feedback from the baseline assessment and proposals for the project was presented to the Board in April 2014. Following the April Board meeting the Chairman and CEO endorsed ten change packages for the Mater Board on Board QI project. The final phase one project QI report was received by the Board at their December 2014 meeting.

2 Methods

The project followed the model for improvement methodology (Langley, Moen et al, 2009), i.e. the project was made up of three fundamental questions (What are we trying to accomplish? How will we know a change is an improvement? What change can we make that will result in improvement?). These questions ensured that there was a clear aim for each change and that the project group could demonstrate the achievement of the aim. These questions drove a series of Plan-Do-Study-Act (PDSA) Cycles, i.e. the project group planned a change, implemented (made) the change, studied the effect of the change through observation, measurement and survey of the Board members, and acted/revised the change in response to the feedback.

2.1 Project initiation

A project charter was developed to kick start the project and support discussion with the CEO, chair and deputy chair. Following direction from the CEO and chair, a full project initiation document was developed, which was inclusive of project aims and objectives, timeline, deliverables, risk analysis, communication plan, measurement plan, driver diagram and operational definitions (see Appendix 1 for project initiation document).

Between January and December 2014 the project group met formally 20 times, in addition to other individual meetings where required.

2.2 Ethical mindfulness

The CEO and project team deemed the QI project exempt from ethics review as it was not intended for research purposes. At commencement of the project, Board members were given information on, and agreed to participate in, semi-structured interviews. Board members were also asked to complete a monthly survey should they wish to do so. Interview responses were anonymised and surveys were completed anonymously. The QI fellows maintained overall responsibility for collection, analysis, reporting and security of data and findings. The QI fellows were mentored by external improvement experts and Scottish Patient Safety Programme throughout the QI initiative, and were accountable for best practice to relevant professional regulators.

2.3 Creating the baseline

Prior to the introduction of change packages, the QI fellows examined the Board baseline in relation to quality of clinical care through semi-structured interviews with Board members and a review of previous meeting agenda and minutes.

2.3.1 *Listening to the voice of the directors*

In order to identify the Board members' needs in relation to the picture presented to them on quality of clinical care, their understanding of same, and their assessment of the Board's ability to take action, the QI fellows undertook semi-structured interviews with the fourteen members as of March 2014 (see Resource 1 for interview guide). Additional members joined the Board in April 2014, and a further discussion took place with them. The themes identified from the interviews guided the approach to the identification of the project change packages.

2.3.2 *Review of Mater Board of Directors' meeting agenda and minutes*

The QI fellows were provided with on site access to the agenda and minutes for the monthly meetings from June 2013 to January 2014, in order to identify the position, level of discussion and recommendations in relation to quality of clinical care prior to the introduction of change packages, which commenced in February 2014.

The Board agenda configures the meeting and guides the chair in conducting the business. The agenda is set by the CEO in consultation with the chair of the Board. To gain an insight of the position of quality of clinical care indicators a map of the agenda items for each meeting was prepared.

The project group identified ten quality of clinical care indicators and the minutes were reviewed to determine the baseline level of engagement with these indicators (see Figure 1). It was found that hand hygiene was discussed frequently by the Board, but other indicators were not discussed (further detail, including these measures are in the 'action' – section 5 of this report).

Figure 1: Level of engagement scale

Levels	0	1	2	3	4	5
Indicators	Not on the agenda or reported in minutes	In supporting papers but not reported in the minutes	On the agenda and/or reported as presented to the Board	On the agenda and/or reported as discussed by the Board	On the agenda and/or reported as discussed and an assessment made by the Board	On the agenda and/or reported as discussed and a recommendation made by the Board

2.4 Change packages

The preliminary report described the background, baseline and plan for the Mater Board on Board QI project. Arising from the direction given by the Directors during the interviews, the reviews of the Board agenda and minutes, and examination of the international literature and international Boards known to lead in this area, ten proposed change packages, to support the Board in focusing on quality of clinical care, were presented to the Board. These were agreed by the Board for implementation over a ten month period (February to December 2014), as follows, The Board of Directors:

1. Monitored ten quality of clinical care indicators introduced to the Board on a phased basis.
2. Received a monthly Quality Dashboard and report on quality of clinical care indicators.
3. Strengthened their understanding of quality of clinical care indicators through a workshop (and one to one support) designed for Board of Directors.
4. Increased their knowledge of best practice in getting Boards on board with quality and safety through targeted reading.
5. Shared experience and learned from other Board's approach to quality and safety by meeting with Sir Stephen Moss on the 5th June 2014.
6. Invited (Non-Executive Directors) to participate in quality and safety walk-rounds to hear directly from patients and staff to gain greater understanding of context and environment related to the quality of clinical care indicators being monitored by the Board.
7. Restructured the agenda for the Board of Director meeting to include quality of clinical care indicators. With the aim of this being the first or second agenda item (after the minutes/review of recommended actions) for each meeting.
8. Restructured the meeting agenda to allow 25% of the meeting for the quality of clinical care section (verbal reports and dashboard) of the Board meeting.
9. Used the communication tool ISBAR to structure the Board of Directors' discussion of the quality of clinical care indicators (identify, situation, background, assessment and recommendation).
10. Will restructure the meeting minutes to include meeting times and an index of Board assessments, decisions and actions.

2.5 Measuring the changes

In order to understand how well the intervention was implemented and outcomes associated with the intervention, where possible, the following measures were undertaken:

1. Board members rated the usefulness of the 'picture' of quality of clinical care that they received at each Board meeting, as measured by completion of a self reported questionnaire at, or immediately after, each meeting.
2. Board members' self assessed confidence in understanding of the quality of clinical care indicators presented, as measured by completion of a self reported questionnaire at, or immediately after, each meeting.
3. Percentage of Board meeting time spent discussing quality of clinical care, as measured by observation at the meeting.
4. Board members rated adequacy of time given to discussion on quality of care, as measured by completion of a self reported questionnaire at, or immediately after, each meeting.
5. Position of quality of clinical care on the agenda.
6. Level of engagement in relation to each quality of clinical care indicator, as measured by review of the discussion recorded in the minutes.
7. Number of assessments (defined as 'the interpretation of the information to make an educated conclusion about quality of clinical care) on the quality of clinical care indicators, as measured by review of assessments recorded in the minutes.
8. Number of recommendations (defined as 'the Board makes a recommendation to request action of the Executive') on the quality of clinical care indicators, as measured by recommendations recorded in the minutes.

See the project initiation document for the QI project measurement plan (Appendix 1). The results of these measures are reported in the relevant sections below.

3 Picture of quality of clinical care

3.1 Introduction

'Picture of quality of clinical care' was defined in this project as the visual and numeric presentation of quality of clinical care information. For data to be useful in assuring or improving quality of clinical care, it must measure aspects of care that are important facets of quality of clinical care and it must do so accurately and in a timely way. It must also allow for comparison within the organisation over time, to identify improvement or dis-improvement and it should allow for comparison with other organisations in order to identify if the organisation can improve further. This data must then be analysed and interpreted to provide information that is fit for the different purpose of its users.

A hospital Board of Directors' role is to assure the quality of clinical care across the whole spectrum of services provided by the hospital and to provide leadership and strategic direction to the hospital. Therefore the 'picture of clinical care' that is required by a Board of Directors should be comprehensive, i.e. with a view of a cross section of all important aspects of care, and should be outcomes focused.

The detailed and process information that is required to support the executive management of the hospital is not suitable for the purposes of the assurance mandate of the Board.

3.2 Ideas from Board of Directors

During the semi-structured interviews the members of the Board of Directors provided direction on the 'picture' that they require. The themes identified were:

- Present the Board with data specifically designed for the Board
- Support the Board in interpreting this information by providing definitions for medical terminology, by providing executive summary and highlighting issues for discussion
- Improve the presentation of the information with more use of graphs, more 'red amber green' ratings with comparable hospitals and trends and comparison with peers and larger font
- Add information on clinical audit, legal issues and mortality
- Tailor the report to line up with the new clinical directorate structure, the hospital strategy and external reporting requirements such as HIQA.

The Board members also identified direction in relation to the picture they require in the monthly survey. The themes identified in the six completed months of surveys were:

- Trend lines critical for understanding
- Investigate variation in the measures by ward and to provide detail on that variation
- Add additional indicators to the ten included in this project – patient experience time in the emergency department and waiting lists
- Extend the patient experience measure of nursing care to include all hospital care, including e.g. medical and food
- Support the Board's interpretation of the measures and papers presented by asking two Directors to lead on comment and discussion on the paper presented by the lead executive
- Add case studies to provide context to the measures
- Learn more about how 'best in the world' hospital Boards operate.

3.3 Literature review and experience from other settings

The search for a few good indicators begins by having a clear understanding of why you are engaged in measuring performance in the first place (Lloyd, 2005: 53). Responsible leadership demands that the hospital knows its data better than anyone else. It further

requires that the hospital has processes in place to accurately and consistently obtain a balanced set of measures that monitor clinical outcomes, functional status, patient experience, process effectiveness and resource utilisation.

Lloyd (2005: 68) advises that 'a balanced approach to indicator development does not mean, however, that you have to measure 30 or 40 indicators. Focusing on the vital few (with emphasis placed on the word few) is preferable to assembling an unmanageable array of indicators that require a small army to collect, analyse, and interpret'.

Based on their research, the Health Care Advisory Board (2000) identified four key elements of an effective dashboard:

- Building a dashboard around a balanced set of performance measures
- Selecting a fairly austere set of measures (i.e. keeping it simple by selecting the vital few measures, usually 15-30 for whole balanced score card inclusive of quality access and cost)
- Presenting data in graphic displays (rather than tabular formats)
- Developing action triggers (i.e. setting targets and goals that trigger the need for action).

They also summarise the learning categories for health service provider dashboards, as:

- Quality (clinical and service quality)
- Satisfaction (patient, family, employee and physician)
- Operational effectiveness/efficiency
- Financial performance.

A number of organisations were identified, where the information and presentation on quality of clinical care indicators were considered to provide excellent examples of information fit for the purposes of a Board of Directors. These included NHS Tayside, Salford Royal NHS Foundation Trust and NHS West Hertfordshire. The themes identified in the Quality Dashboards of these organisations were:

- Focus on outcome measures, including hospital mortality (adjusted and unadjusted, and after certain conditions, e.g. stroke, fractured neck of femur), readmission rates, length of stay, safety thermometer (a measure of harm and proportion of patients harm free during hospital stay), percent of prescriptions correct, MRSA rates, Clostridium Difficile rates, orthopaedic surgical site infection, rate of falls with harm, measures of patient and staff satisfaction, staff absence rate, pressure ulcers, cardiac arrests, artificial airway associated pneumonia
- Presentation of information using summary Quality Dashboard, with supporting documents that describe the information in text
- Use of statistical process control charts, which show variation month by month and identify where that variation is more than would be expected (special cause effect)
- Inclusion of targets where they exist, but in the absence of targets measures tracked over time
- Publication of agenda, minutes and supporting documentation (with the exception of personally identifiable or commercially sensitive information).

3.4 Changes delivered by this project

For phase one of the Mater Board on Board Project the focus was on developing the quality of clinical care indicators – one section of a balanced score card – as it is recognised that this area to date has received less focus than some other areas. It is acknowledged that the ultimate goal is to have a Mater Board balanced score card incorporating a quality of clinical care dashboard.

The aim of the project group was to produce a dashboard fit for the purposes of the Board, i.e. a dashboard that the Board members considered provided the right information, in the right way, and that is timely and comparative.

3.4.1 Quality of clinical care indicators

Guidance in relation to 'Boards on Board' advises that the Board should focus its attention on high level outcome measures (Conway, 2006). Therefore the emphasis is placed on outcome indicators, with process indicators where they support the outcome indicator

(for example Clostridium Difficile and Hand Hygiene). In addition to this, phase one of the project limited the number of new indicators introduced to a maximum of three indicators per month, in order to allow time to build understanding and knowledge of the measures at the Board meeting.

During phase one of the project ten quality of clinical care indicators were presented and discussed in the 'quality assurance' section of the Board meeting. Indicators were chosen based on their performance against criteria developed by the project group (① data available monthly, ② data readily accessible, ③ data current, ④ local importance, ⑤ national requirement, ⑥ data robustness, ⑦ metadata available, ⑧ target availability, ⑨ ability to benchmark (see Resource 2). Internationally standardised hospital mortality is included in the indicators used to assess the quality of clinical care. Many of the Directors (during the interviews) expressed a desire to have this indicator reported to the Mater Board. This indicator was not available during the project time scale. The Mater phase two project group are working with the National Office for Clinical Audit (NOCA) on including mortality indicators in the Quality Dashboard. While for phase one of the Mater Board on Board Project, only indicators currently available were included, with the exception of mortality, it is positive to note that the indicators are very much in line with those measured in leading international organisations.

These indicators were introduced on a phased in basis, as follows (see details of the schedule in Appendix 1):

1. Medical readmission rates
2. Surgical readmission rates
3. Patient experience of nursing care
4. Staph. Aureus rates
5. C. difficile rates
6. Training in hand hygiene (online or in person)
7. End of life care in a single room
8. Presence of family room on ward (and further standard of room)
9. Falls
10. Smoking cessation.

3.4.2 Board of Directors' Quality Dashboard with ISBAR report

In order to present the indicators in a format useful for the Board, i.e. presented in a way that is easy to understand, comparative and timely, the project group used the executive dashboard on Diveport (the hospital data management system) as a template. The project group, which included the hospital information analyst, developed a Board of Directors' Quality Dashboard. Feedback provided by the monthly survey from the Directors was taken into account to deliver improvements to each iteration of the dashboard – sixth version (see Figure 2). Between version one and six the following changes were made: (i) including text on the target for each indicator; (ii) adding Red, Amber, Green indicator before the scale; (iii) including, where possible, a trend for the last 12 months; (iv) adding a trend line to the trend graph; (v) including desired direction arrow for the trend line; (vi) putting date range in the dashboard title; and (vii) adding further detail in the key.

The facets of the dashboard (version 6) were:

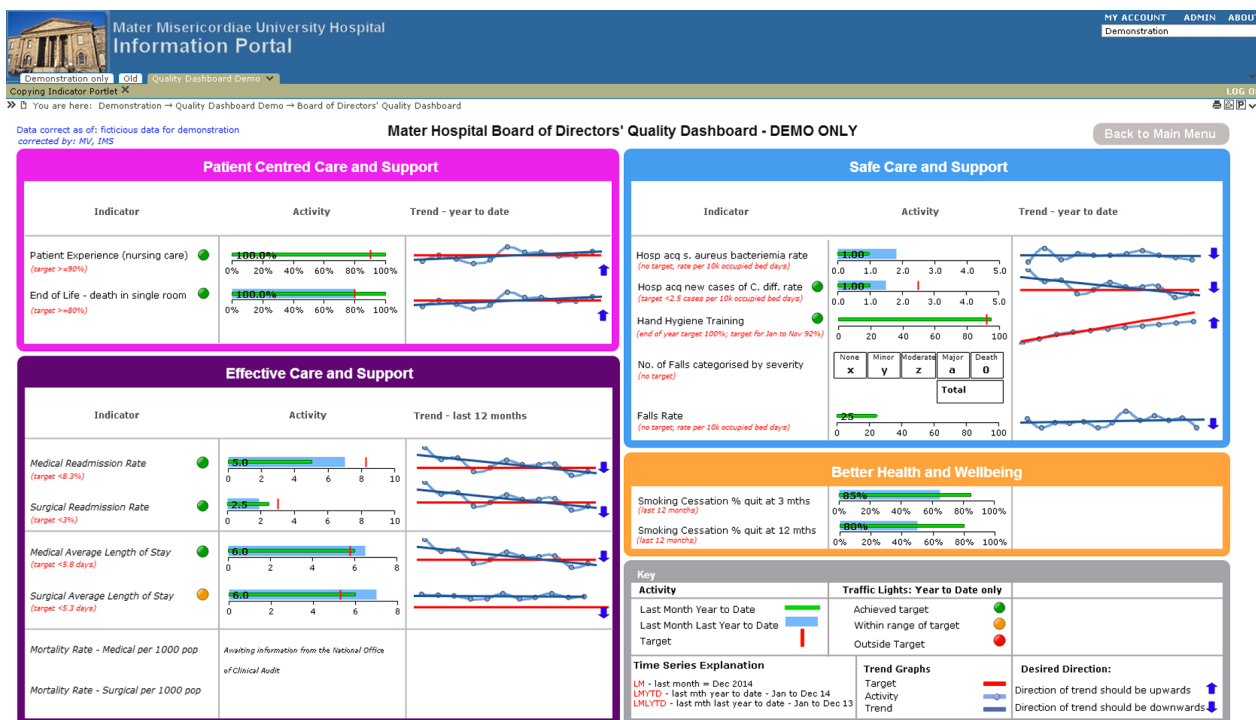
- It is structured on the four domains of quality of the *National Standards for Better Safer Health Care* (2012), and colour coded in line with the themes of the standards: (i) person centred care and support; (ii) effective care and support; and (iii) safe care and support; (iv) better health and wellbeing
- The indicators were introduced into the shell of the dashboard in a stepwise approach, with every month building on the previous month.

Describing each indicator from left to right:

- Each indicator is described with the short definition, and the target, where it exists, is listed
- A Red, Amber or Green dot is placed next, which indicates if the target is met (green), is nearly met (amber) or not met (red)
- Activity charts show the average score year to date (green) and for the same time period last year (blue) along with the target (red line)
- Trend last twelve months (where the information exists) shows the monthly measure for the last twelve months, a trend line and the desired direction.

Figure 2: Board of Directors' Quality Dashboard

Note: the dashboard contains sample data prepared for illustrative purposes



An information pack is provided with the dashboard in order to support its interpretation. This contains a summary table listing the indicator, description, rationale, calculation and target. It also includes a full description of the indicator using the communication tool ISBAR, a technique to plan and structure communication, which gives focus to *identifying* the indicator, describing the current *situation*, giving *background* information on contextual factors that have occurred, providing an *assessment* on what this means and suggesting a *recommendation* the Board may wish to give the Executive arising from a review of the indicator. See Resource 3, Resource 4 and Resource 5 at the end of the report for the complete ISBAR algorithm, guide for writing an ISBAR report and the Board of Directors' Quality Dashboard (with sample data).

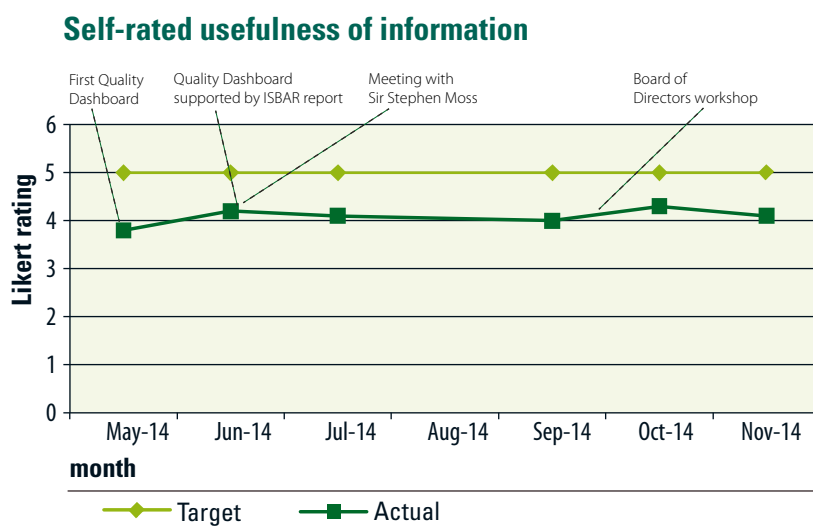
3.5 Measuring the changes

During the QI project, thirteen indicators were introduced. Nine of the original ten and three additional (smoking cessation and medical and surgical length of stay) were added. The Board discussed the approach to introducing the final phase one indicators 'mortality rate' at the November Board meeting.

In May, the first Board of Directors' Quality Dashboard was introduced, and further adapted based on members' survey feedback in May, June, July, September, October and November.

Board members rated the usefulness of the picture in relation to quality of clinical care as improved from 3.8 following the first Quality Dashboard to 4.1 following the sixth dashboard on a likert scale of 1-5 (see Figure 3).

Figure 3:



Achievement: A Board of Directors' Quality Dashboard. During phase one the QI project aim was somewhat achieved as the Board of Directors rated the usefulness of the information on quality of care indicators had improved by 0.3 (8%). The original aim of a minimum increase of two levels on the likert scale was not possible to achieve as there was no baseline measure before the introduction of the dashboard.

Benefit to the Board..... it got the Board thinking much more deeply about quality aspects of care and how we are providing care...it enabled us to think and reflect...are we getting the right information on the quality of clinical care ...what information do we need to make decisions on quality, and align these with very difficult decisions on budget and finance...it really influenced the Board in putting quality at top of the agenda where historically finance would have been (Executive Director).

3.6 Next steps

During phase one of the project, a number of next steps were identified, for consideration in phase two and three of the project. These include:

- Extend the number of indicators reviewed to provide a balanced picture of quality of clinical care outcomes and important process measures, .mortality, medication safety, antimicrobial stewardship, emergency care measures, and transfers during stay. Improve access to information to enable reporting on indicators, i.e. some of the measures initially planned for inclusion could not be collated in a timeframe or format to allow inclusion in the Quality Dashboard, for example hospital acquired pressure ulcers
- Develop Quality Dashboard to provide comparisons with peer hospitals and nationally
- Automate information collection. Currently the hospital information analyst must manually enter a number of the indicators onto Diveport for inclusion in the dashboard. Automating this process would be more efficient and reliable
- Expand the Board of Directors' dashboard to encompass access and finance as well as quality to produce a Board of Directors' balanced scorecard.

4 Understanding

4.1 Introduction

'Understanding of quality of clinical care' was defined in this project as the ability to comprehend the indicators in accessing the quality of clinical care. Measurement in the field of healthcare is complex. The Mater Misericordiae Board of Directors, like most Boards, is composed of a mix of Executives and Non-Executives medical professionals and other professionals. There is no statistician or information expert on board, although a minority of members do have expertise in the measurement of clinical care. Therefore one of the key aspects of phase one of the Mater Board on Board Project was to identify and deliver training to the Board in order to support them in improving their knowledge and understanding of quality of clinical care indicators.

4.2 Ideas from Board of Directors

During the semi-structured interviews the members of the Board of Directors were asked what tailored training they would find useful in improving their knowledge and understanding of quality of clinical care indicators. The training identified as useful included:

- A workshop specifically for Directors on quality of clinical care indicators
- Participation in quality and safety walk-rounds (also known as Leadership walk-rounds)
- Meeting with an international expert on hospital Boards
- Access to resources and reading material for self directed learning on best practice in how Boards monitor and receive assurance on quality of clinical care.

During the semi-structured interviews a number of the Directors also raised concern around the recommendation in the HIQA (2012) Tallaght Hospital investigation report that

'the Board should comprise Non-Executive Directors and a chairperson and, in keeping with good governance, individuals with conflicts of interest, including employees of the hospital and those with other relevant conflicts of interest, should not be appointed to the Board. The Chief Executive, and other designated executive officers (to include as a minimum, the equivalent of the director of finance, medical/lead Clinical Director and Director of Nursing) should be formally in attendance at the Board with combined shared corporate accountability for the effective governance and management of the hospital' (HIQA, recommendation 9).

The Directors identified the strength of a Board comprised of both Non-Executives and executives with individual and collective responsibility and accountability for overseeing the effective governance of the organisation.

4.3 Literature review and experience from other settings

The international literature suggests that hospital Boards' capacity to understand and engage in improving quality is variable. The Institute for Healthcare Improvement (IHI) faculty undertook an assessment of more than 5,000 hospitals in the United States in 2006 and found that Boards fall into four general categories with respect to their level of engagement in improving quality and safety, their effectiveness in doing so, and their understanding of quality principles:

- Actively engaged and capable: already leading a high-performance organisation and wondering how their Board can work better
- Actively engaged; often showing that commitment through high-profile event but needing a much stronger foundation for continued work on improvement
- Not fully engaged but having strong, latent capabilities and talent on the Board, looking to light a fire with the full Board but not sure how
- Neither engaged nor capable, feeling that quality is just fine and viewing quality of care as not the Board's proper business but rather that of the medical and executive leadership (Conway, 2006).

Jha and Epstein (2013) conducted a survey, published in 2013 to compare English hospital Boards with their US counterparts in terms of attention to quality of care. They found that while UK Boards had more expertise and spent more time on quality of care than US Boards, that the association between English hospital performance on quality metrics and Board engagement in quality was generally not as substantial as in the earlier US survey. Both English and US Boards tend to greatly overestimate the quality performance of their hospitals. They concluded that there is room for improvement in both countries in terms of improving Board

expertise and focus on key quality metrics, and to hold managers accountable for the delivery of safe and effective health care (Jha and Epstein, 2013).

Quality and safety walk-rounds (also known as Leadership walk-rounds) are evidence based structured process to bring Board members, senior managers and frontline staff together to have quality and safety conversations with a purpose to prevent, detect and mitigate patient/staff harm. The aims in introducing walk-rounds are multiple, to:

- Demonstrate senior managers' commitment to quality and safety for patients, staff and the public
- Increase staff engagement and develop a culture of open communication
- Identify, acknowledge and share good practice
- Support a proactive approach to minimising risk, timely reporting and feedback
- Strengthen commitment and accountability for quality and safety (HSE, 2013).

They provide a formal process for members of the executive/senior management team/members of the Board (for example CEO, Chief Financial Officer) to talk with staff and patients about safety issues in their unit or team and show their support of staff for reporting errors/near misses.

During the project, a visit to NHS Tayside occurred to share their learning in relation to the functioning of their Board. In order to support the Boards' role in assuring the quality of care, Tayside run bimonthly Board development training, which for example covers: primary care strategy 2020; service planning; interfaces; infrastructure; workforce and leadership; and bringing the picture alive for three critical work streams (mental health, shaping surgical services, reshaping older persons care). Executive and Non-Executive Directors undertake training together. This ensures that the Non-Executive Directors have the skills required to undertake their key role of assessing objectively the hospitals performance and holding to account executive members on delivering that performance.

During the project (19th and 20th August) members of the project group also visited Salford Royal NHS Foundation Trust. The aim was to gain first hand experience of how Salford, widely recognised for its work in quality and safety has achieved successes. The visit focused on Board of Directors' approach to quality of clinical care, measurement for Boards, setting up a quality improvement directorate, and the Salford organisational development and patient experience strategy. A Board member shared top tips from their Board's focus on quality and safety, which included:

- Learn together – bring Non-Executive and Executive Directors together for structured developmental programmes – in Salford there are four Board one day sessions per year, along with a developmental section of each day long Board meeting.
- Kick start the Board's development in governing for quality through participation in the Institute for Healthcare Improvement (IHI) two-day course, "From the Top: The Role of the Board in Quality and Safety," which elucidates six Board activities that IHI and governance experts have identified as critical to meaningful change.
- Engage deeply with the organisation. Executive and Non-Executive Directors quality and safety walk-rounds commenced in Salford in 2007 – these have worked really well; the walk-rounds have developed both in terms of the questions asked and in the style and approach – now evolved to executives shadowing staff.
- Find different ways to bring patients into the Boardroom, e.g. tell patient stories in different formats, recently the Boardroom was covered in laminated posters of silhouettes of men, women and children with red symbolising a death and black symbolising harm that occurred in the Trust. A synopsis of the harm was placed in the centre of the silhouette. One third of their Board meeting time is spent on QI.
- High visibility of executives, including seven day working for all executives, using a weekend roster.
- Deep staff engagement. Salford believes that the answer lies with the staff and that the Board and executives' role is to create the conditions for staff to lead and implement improvements. They use the model for improvement and breakthrough collaboratives.

4.4 Changes delivered by this project

4.4.1 Learning from Sir Stephen Moss

Sir Stephen Moss, knighted for his work as chair of the Board of NHS Mid-Staffordshire following the catastrophic failures that happened in that organisation, visited MMUH on 5th June 2014. He has extensive experience of supporting hospital Boards to focus on quality of clinical care through his role as Director of Nursing, CEO, and chair of hospital Boards. Four meetings were held:

1. An introductory meeting with the CEO and Executive Management Team, in which he briefly outlined his career and experiences at Mid Staffordshire.
2. Presentation to staff on 'How we all matter in delivering quality and safety' – with the aim of sharing experience of quality and safety the Mid-Staffordshire experience. This included top tips for developing a culture of QI. The presentation was given in the Freeman Theatre followed by question and answer session to over 100 staff and guests from the hospital group, including teleconferencing with St Vincent's University Hospital, Elm Park, Mullingar Hospital and St Luke's, Kilkenny. The presentation is available to all staff on the Mater internet.
3. Meeting with the Board of Governors and Board of Directors. This commenced with a presentation 'Sharing Board experiences of getting Board on Board with quality of clinical care', followed by discussion and exchange of experiences.
4. Meeting with Dr. Philip Crowley, HSE, National Director for Quality and Patient Safety. A video of Dr. Crowley in discussion with Sir Stephen Moss was made – examining the role of Board of Directors in quality and safety. This was made available on the HSE YouTube channel.

A summary learning report of the visit is in Appendix 2.

4.4.2 Targeted monthly reading

Each month the members of the Board received an information pack. Included in this were one or two key articles from the international literature. For the full list, and other essential reading see the reference list at the end of the document (*Targeted reading is marked with blue symbol * on the Reference*).

4.4.3 Board of Directors' Workshop on Quality of Clinical Care Indicators

A workshop to support the Board members in understanding quality of clinical care indicators was held on the 26th September 2014. The aim of the workshop was to support the Board of Directors in understanding and using the Quality Dashboard to hold the hospital executive to account on the quality of clinical care delivered.

The objectives of the workshop were that the Board of Directors gained:

- An understanding of the context within which the Board is working
- An understanding of quality of clinical care indicators
 - Identity: of the indicator – the reason it's measured, the unit it's measured in, the target, the desired direction
 - Situation: trend over time, variation
 - Background: factors that impact on indicators
 - Assessment: skills in attaining assurance on quality of clinical care in order to question and make an assessment on the information presented
 - Recommendation: skills to make recommendations to the Executive Directors.

See Resource 11 for an outline of the programme for the workshop.

4.5 Measuring the changes

The workshop held on 26th September 2014 was attended by eighteen people comprising 2 Non Executive Board Members, and 4 Executive Board Members, along with Phase 1 and Phase 2 project group members.

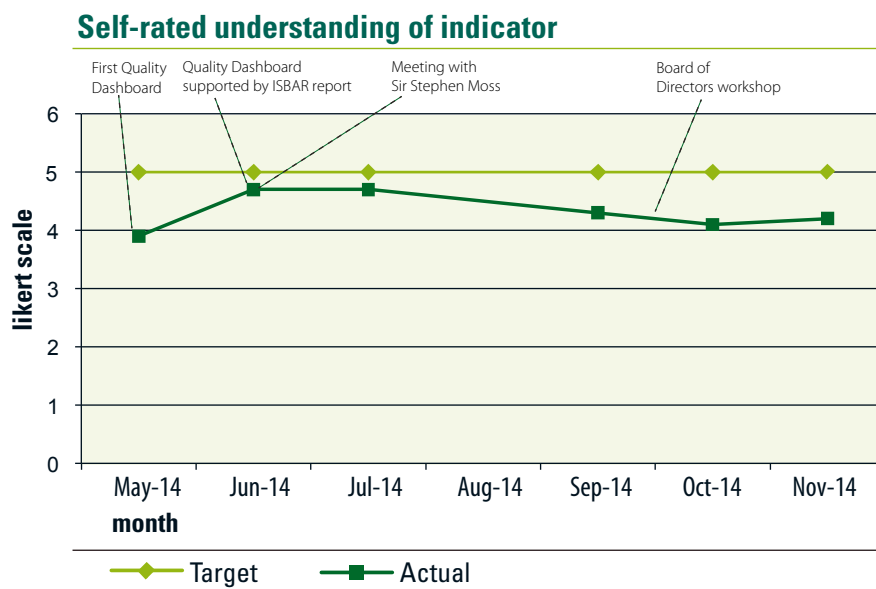
14 evaluation forms were completed (78% response). Overall the workshop was well received.

- 100% of respondents agreed or strongly agreed the workshop met their expectation and improved their interpretation of the Board of Directors' Quality Dashboard.
- Both the Non-Executive Directors and Non-Clinical Directors felt the workshop improved their understanding of the quality of clinical care provided in the hospital.
- 100% of respondents agreed or strongly agreed they felt more confident in using the ISBAR communication tool as a methodology for both structuring the analysis of the quality indicator presented and enabling the Board to hold hospital executives accountable on the quality of clinical care delivered.
- There was a general consensus among respondents that they would have liked more time for the interactive learning piece.

The presentations on the patient stories were reported as invaluable for relating the information represented on the Quality Dashboard to patients, and supporting discussion, and were considered to be very useful going forward.

Board members rated their confidence in understanding quality of clinical care as improved from 3.9 following the first Quality Dashboard to 4.2 following the sixth dashboard on a likert scale of 1-5.

Figure 4:



Achievement: The phase one QI project aim was somewhat achieved as the Board of Directors rated their understanding of quality of clinical care indicators as improved by 0.3 (8%). The aim was to increase understanding by a minimum of one level on a likert scale from one to five. (See Figure 4)

Board meeting with Sir Stephen Moss.... I knew that anything he said was coming from the depth of his experience.. he was so totally honest.. he gave us so much to absorb .. he gave us an outline of what can happen but also what to watch out for.....I have struggled over the last couple of years with the business model approach to caring for the sick and find it difficult to reconcile the two...a milestone in the history of the hospital. (Executive Director)

4.6 Next steps

A formal system for Executive Managers to undertake quality and safety walk-rounds was introduced in 2013. It is proposed to extend this arrangement to include Non-Executive Board members. An introduction to the walk-round process was given at the Board of Directors' workshop in September 2014.

5 Actions

5.1 Introduction

'Action' in this project was defined as the Board requesting follow-up/activity of the Executive Management of the hospital in relation to quality of clinical care information that is received at the Board meeting.

The Board agenda configures the meeting and guides the chair in conducting the business. The agenda is set by the CEO in consultation with the chair of the Board. It determines what is discussed and the amount of time devoted to discussing the quality of clinical care provided across the Mater Hospital services. The minutes record the discussion, decisions and recommendations made by the Board and are the key record and communication of the Boards' direction to the hospital. Therefore, these documents are useful tools in supporting the Board to prioritise and make recommendations to the Board on actions to improve quality of clinical care.

It is development of the culture and the acquisition of skills and knowledge that supports the Board to actively question, make assessments and make recommendations to the Executive in relation to quality of clinical care.

5.2 Ideas from Board of Directors

During the interviews suggestions were made by Directors (based on experience of other Boards) for enhancements to the meeting agenda and minutes, as well as to the running of the meeting itself.

Suggestions included were:

- Create a specific section of the meeting to focus on quality of clinical care
- Allocate time for each section to assist the chair in maintaining a balanced focus on access, finance and quality
- Ask for one or two Board members other than the relevant Executive to lead the response/discussion on the presented Board paper.

The Board also specifically asked for a search to identify Irish or international Boards who are exemplars in the field of quality in order to learn from their agendas and minutes.

5.3 Literature review and experience from other settings

There is a growing literature providing insight on how Boards can lead and assure the quality and safety of their organisations (Conway, 2008, Lloyd, 2004, Jha and Epstein, 2013, The Walker Company, 2010). The key messages are to:

- Ensure that there is a strong and consistent focus on quality in the Board agenda
- Allocate 25% of Board time for quality and safety issues (Salford Royal Foundation Trust are now allocating 33.3% of their Board meeting time to quality and safety)
- Ensure that there is a balance of measures that describe the quality of care
- Focus on the critical few big dots/outcome measures
- Use patient stories and anecdotal information but support it with evidence
- Engage in robust dialogue at Board level on quality of care; the Board must not be a passive recipient of information
- Keep focus at strategic, rather than operational level
- Set aims for the hospital
- Understand the patients that the hospital serves – this may be through having a patient representative as a Board member, engaging with patient groups and listening to patient stories
- Understand the community the hospital serves
- Ensure Executive accountability
- Address conflicts of interest in Board members
- Ensure the Board members have the leadership skills required to lead the hospital and put systems in place to build capacity at Board level.

The role of the Board and CEO should be clear. Board effectiveness relies on the ways in which the Board members translate their knowledge and information into quality and safety plans with measurable goals, maintain oversight on progress to these goals, and hold the CEO and the hospital accountable for goals (see Table 2).

Table 2: Role of the Board vis a vis the CEO around addressing quality questions

Role of the Board in answering the quality questions	Role of the CEO in answering the quality questions
<ul style="list-style-type: none"> – Delegate – Facilitate – Engage – Approve – Monitor – Evaluate 	<ul style="list-style-type: none"> – Creating the quality plan – Communicating – Integration – Organisation and operational alignment – Execution – Monitoring and reporting – Evaluation and performance

Source: Canadian Patient Safety Institute (2011)

It is not common for Irish or US hospitals to publish their Board agenda and minutes. The NHS does require publication of agenda and minutes by all hospitals. Three Trusts identified as leaders in the field were (i) West Hertfordshire Hospitals NHS Trust (ii) Salford Royal NHS Foundation Trust and (iii) NHS Tayside Board. The three Boards hold their meetings in public and the agenda minutes and supporting papers are made available on their website. One hospital in Ireland, Tallaght Hospital and the West/North West Hospital Group make their monthly Board agenda, minutes and supporting papers available on their website.

The sample agenda and minutes demonstrate a variation in style, in general the meetings:

- Commence with a patient story
- Include a declaration of interests
- Have a section for patient safety and quality (different titles) early on the agenda
- Include a QI Dashboard.

Also

- Agenda items are numbered for reference purposes
- Agenda identifies the matters with supporting paper and/or oral presentation
- Agenda identifies the matters for notice (information), for approval and for decision
- Minutes identifies and numbers decisions of the Board.

Sir Stephen Moss, during his visit to MMUH, made a number of suggestions to support action at Board level. These included:

- Use anecdotal information but require it to be backed up by evidence
- Ensure frontline staff can access the Board without fear
- Engage actively with patients and the public
- The Board should be comprised of Executives and Non-Executives, clinicians and non-clinicians
- Be completely transparent; hold meetings in public, publish all documents
- Be brave; aware that this transparency will be challenging initially.

5.4 Changes delivered by this project

5.4.1 Restructure Board agenda to include a quality assurance section, early in the agenda, and allocate 25% or more of Board time to this.

The first action of the project was the creation of a new agenda item titled 'Quality Assurance Report' (first introduced in February 2014) where verbal reports from five Executive Directors were discussed.

A proposed minutes template was developed for consideration by the Board, which includes a conclusion for each item and a log of the Boards' recommended actions for follow up. The new minute template (with further amendments) was introduced for the October Board meeting. However, this did not include the log of the Boards' recommendations.

5.4.2 Use adapted ISBAR tool to structure Board discussion and decisions on quality of clinical care

ISBAR has been introduced across the Irish Health System in 2012 as the communication system for the deteriorating patient. This QI project introduced an adapted ISBAR as a tool to structure the Board quality of clinical care papers and the Board discussion around the quality of clinical care indicators. The tool (sixth iteration) was amended based on the project group and members' survey feedback. The changes made between version one and six were as follows: (i) converted from table format to flow processes; (ii) added 'identify' to SBAR – so the same communication tool is being used from the patient to the Board – 'identify' helps to focus the discussion on the specific indicator with clarity on the definition; (iii) changed the description for each element of the communication tool to be more active and explicit on who is the 'lead' for each section of the ISBAR communication (iv) adding a third option to assessment – where this is not enough information; (v) changing the direction of the arrows to clearly end at 'recommendation'; and (vi) including a feedback loop to the next meeting.

The communication tool outlines a number of steps undertaken by the Executive presenting the information:

- identifies the indicator and states why it is important
- outlines the current *situation* i.e. is the target being reached, is it improving or dis-improving
- may provide any relevant *background* or contextual information as to why this is the case.

Following these steps, the tool then leads the Board to:

- make an *assessment* based on the information required, or ask for more information
- make a *recommendation* based on the information provided
- request feedback at the next meeting.

See Resource 3 at the end of this report for the ISBAR tool and Resource 4 for a guide to writing an ISBAR report for the Board of Directors' Quality Dashboard.

5.5 Measuring the changes

To date, the Board agenda has been restructured to include a quality assurance section, although it is not first or second on the agenda.

A proposed agenda template was developed for consideration by the Board, which includes placing quality assurance report as the first substantive item and allocating 25% of meeting time to it, in addition to identifying the lead and the objective for each item.

To date, the proportion of meeting time spent on quality of clinical care has increased from 10% to 25% (target reached in June 2014) and varies on a monthly basis (see Figure 5 and Table 3).

Figure 5:

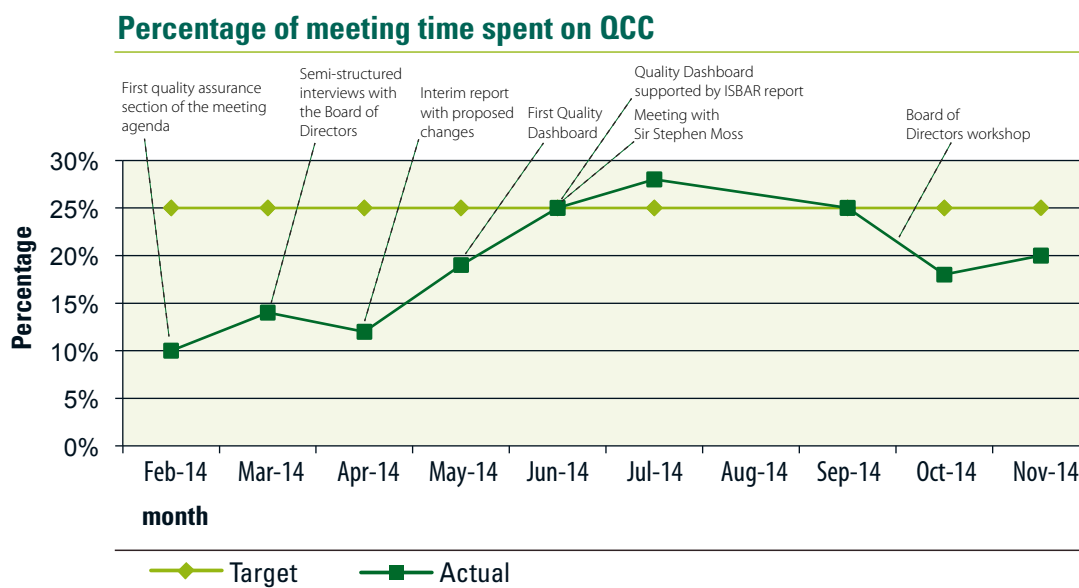


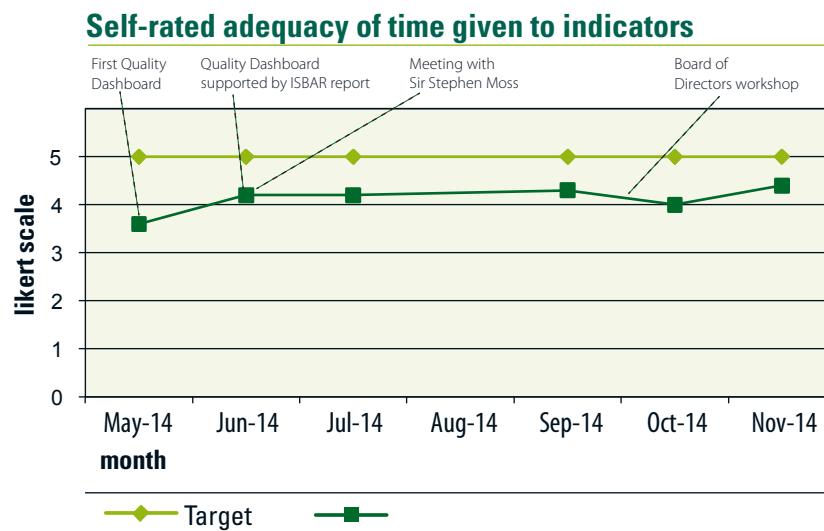
Table 3: Length of the Quality Assurance Report section of the meeting (mins and %)

Date 2014	Start Time	Finish Time	Total meeting time (minutes)	Quality Assurance Report (minutes)	Quality Assurance Report (% time)
25 Feb	16.30	20.00*	210	20	10
25 Mar	16.30	20.00*	210	30	14
29 Apr	16.30	20.00*	210	25	12
29 May	16.30	20.30	240	45	19
24 June	16.30	19.45	195	50	25
22 July	16.40	20.15	235	65	28
9 Sept	16.30	19.45	195	48	25
21 Oct	16.30	20.07	217	40	18
25 Nov	16.30	20.15	225	45	20

*estimate time

The Board members rated the adequacy of time spent on clinical care as improved from 3.6 following the first dashboard to 4.4 following the sixth dashboard on a likert scale of 1 to 5 (see Figure 6).

Figure 6:



The level of engagement, number of assessments and number of recommendations made by the Board on quality of clinical care were observed by the QI fellows to have increased since the introduction of change packages. See Figure 7 for details of the level of engagement scale. Over the six Board meetings hand hygiene, end of life care in a single room and staph aureus reached the top level of engagement (level 5 on agenda, and a recommendation made by the Board), although not all recommendations were noted in the minutes. See figures 8, 9, 10 and 11 for changes in the level of engagement.

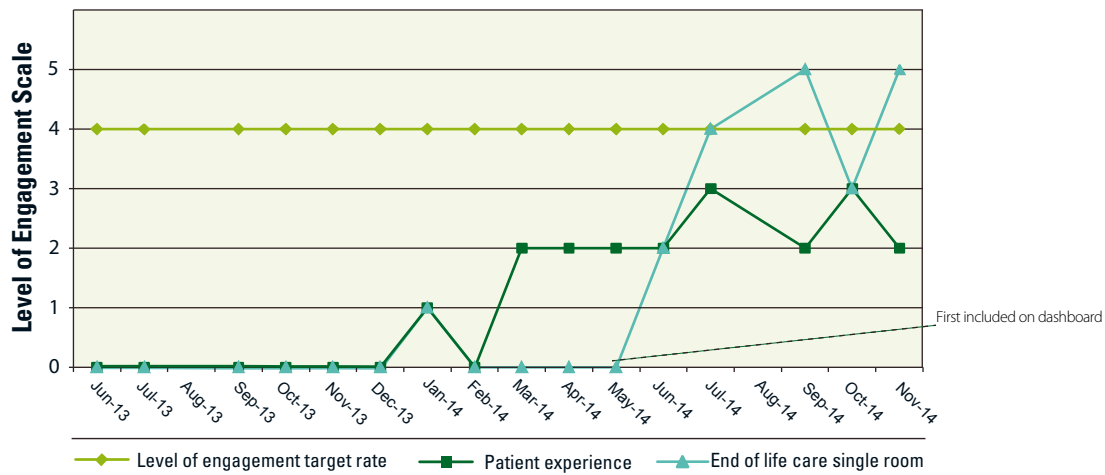
In month 6 it was observed that a Board member asked for follow up on an action requested by the Board previously. This is not captured on a five point scale and raises the question as to whether a sixth point, for follow up, should be added to the scale.

Figure 7: Level of engagement scale

Levels	0	1	2	3	4	5
Indicators	Not on the agenda or reported in minutes	In supporting papers but not reported in the minutes	On the agenda and/or reported as presented to the Board	On the agenda and/or reported as discussed by the Board	On the agenda and/or reported as discussed and an assessment made by the Board	On the agenda and/or reported as discussed and a recommendation made by the Board

Figure 8:

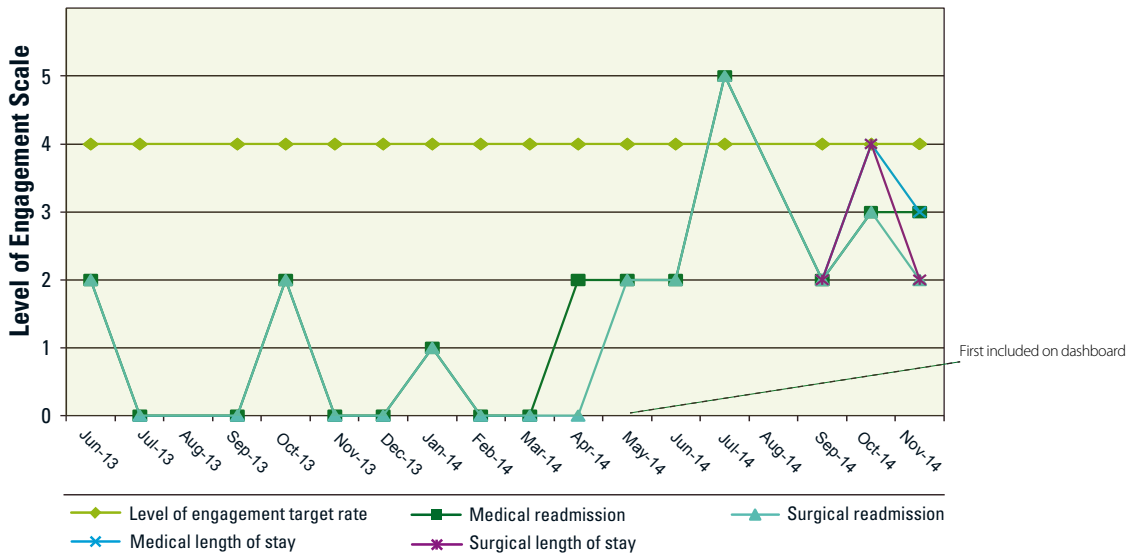
Level of Engagement with Person Centred Care Indicators



Note: score is for level of engagement reported in meeting minutes. The score for Nov 2014 as observed at meeting

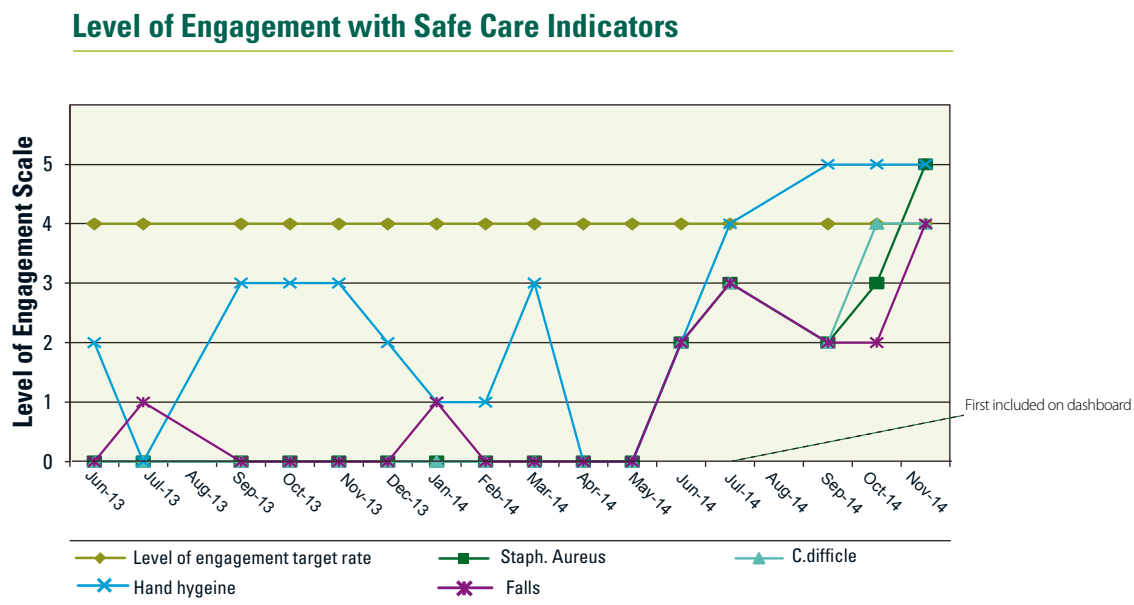
Figure 9:

Level of Engagement with Effective Care Indicators



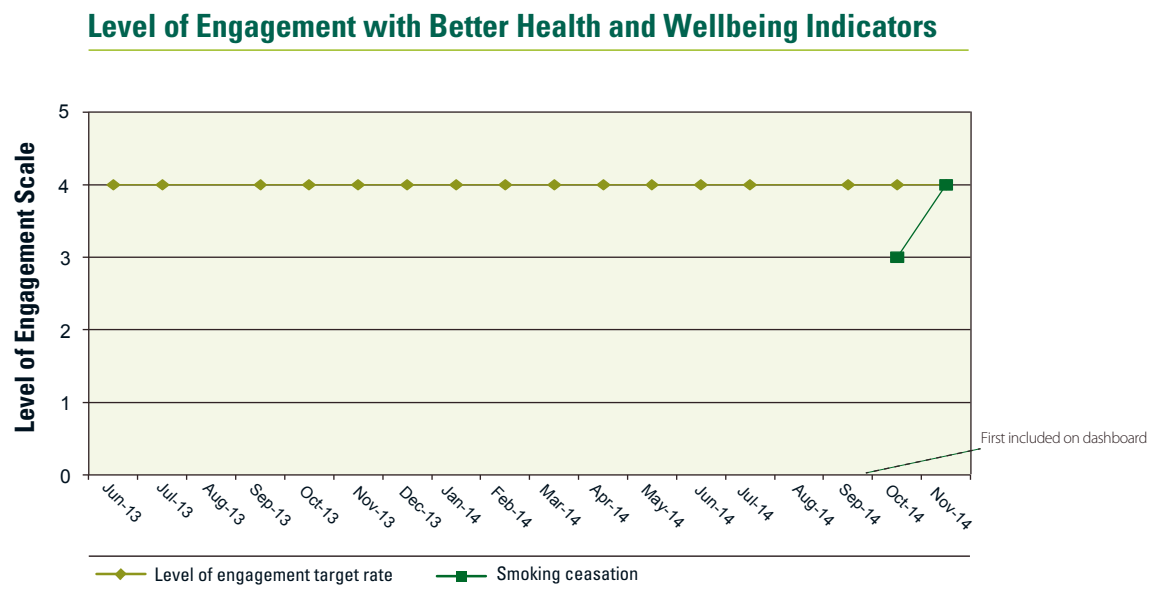
Note: score is for level of engagement reported in meeting minutes. The score for Nov 2014 as observed at meeting

Figure 10:



Note: score is for level of engagement reported in meeting minutes. The score for Nov 2014 as observed at meeting

Figure 11:



Note: score is for level of engagement reported in meeting minutes. The score for Nov 2014 as observed at meeting

An additional question included in the Board of Directors November survey sought feedback on the new minutes format.

The format was very positively received. Board members rated, on a likert scale¹, the new format of the minutes as providing a clearer overview to:

- assess the quality of clinical care provided to patients in the Mater hospital as 3.6
- make recommendations / actions in relation to the quality of clinical care as 3.5.

Achievement: Quality Dashboard and ISBAR report, ISBAR prompt sheet and new minutes format. During phase one the QI project aim was mostly achieved as the Board of Directors rate the adequacy of time and attention given to quality of care indicators as improved by 0.8 (22%). The original aim of a minimum increase of two levels on the likert scale was not possible to achieve as there was no baseline measure before the introduction of the dashboard.

I believe.... .to dedicate 25% of Board time to safe patient care in all its facets ...will not only assist in improving morale for staff but underpin our mission statement to drive the organisational culture we desire ..I have learnt – it is extremely important - to put in systems that convert aspiration to reality...the project has done marvellous things for me as chair of the Board; and my Board of Directors (Non-Executive Director).

5.6 Next steps

Three further change packages were agreed by the Board of Directors to support action on quality of clinical care at Board level. These were:

- Restructure agenda in order that quality assurance section is item 2 or 3. See Resource 7 at the end of this report for a draft agenda template:
 - Allocates time to each agenda item
 - Identifies the lead for each item
 - Identifies the objective for each item (to note, to listen, to approve or to make recommendation)
 - Indicates if there is a paper included and/or for verbal presentation
 - Includes a template for submission of agenda item
 - Quality assurance report scheduled as the first item after the minutes/update on Board recommended actions
- Includes an agenda item for 'new declaration of interests.' See Resource 8 Guidance and Template for Board of Directors declaration of interests
- Restructure agenda to allow 25% meeting time for quality of clinical care
- Restructure minutes to include meeting times and an index of Board assessments and recommendations. See Resource 9 at the end of this report for a draft minutes template:
 - Item reference (link with agenda)
 - Conclusion to each agenda item discussion, 'The Board: noted/ listened/ approved / recommended'
 - Who action is to be taken by
 - A log of the Board's recommended actions for follow up – with the aim of completing the loop by reviewing each month that previous decisions and recommendations of the Board are acted on. Identifies the status of each item: (i) complete (take off the log the following month); (ii) not started; and (iii) ongoing (work being done).

¹ Rated on a scale of 1-10 likert converted to a 1-5 scale measure.

6 Discussion

This QI project was the start of a journey of strengthening the governance of quality and safety within the Mater Hospital. Phase one has been in collaboration with Maureen Flynn and Dr. Jennifer Martin, QI Fellows and members of the Quality Improvement Division, HSE. The project is being continued with phase two, undertaken by Mater staff and led by the quality manager and members undertaking the leadership and quality improvement diploma at the RCPI which commenced in Autumn 2014.

At this point, there is already evidence of early successes; the portion of the Board meeting spent discussing quality of care achieved the 25% target set by the Board on two occasions, the level of engagement in quality of care indicators improved and the Board members rated the usefulness of the information, their understanding of same and the time given to discussing quality of care as improved.

These early successes can be attributed to a number of strengths in the project. The CEO of the hospital is the co-executive sponsor and very actively driving the project, including delivering the Board of Directors' Quality Dashboard. Together with the chair of the Board, this provided the explicit leadership for the project. The project has been effectively resourced, with a project team made up of committed and appropriate MMUH staff, particularly the hospital information analyst and the quality manager who acted as project lead. In addition, two QI fellows were allocated one day per week of the project. The project team also had the added support of the Scottish Patient Safety Programme and Irish QI Fellows. Finally, the Board secretary was key in organising Board meetings, and the support of the secretary ensured that communication to and from the Board to the project group occurred.

The semi-structured interviews were pivotal in gaining an understanding of the needs of the Board members who were the customer of this QI project. The Board members themselves identified the need for the project and the interviews allowed them to direct actions.

The hospital already had in place an IT system (Diveport) that allowed the information analyst to develop and adjust the Board of Directors' Dashboard in response to the needs identified in the QI project.

The quality improvement literature suggests that a 'burning platform' is required to drive change. The visit of Sir Stephen Moss, was felt by many to be that platform to drive and sustain the changes this project has started.

There were a number of limitations in the project also. First, while there was discursive literature on engaging Boards in quality of care, there was a very limited evidence base behind this literature and therefore there were no tools or measures that could be taken from the literature and adapted for use in the Mater. A QI project, using the model for improvement, needs to be able to measure if the change has been implemented and has produced benefits. It was challenging to develop measures. The measures that the team believed to be useful were the total time and percent of meeting time spent on quality of clinical care and the level of engagement scale. The other measures were less useful.

The indicators chosen for the dashboard were indicators of quality care in Irish/international healthcare, however the number was limited by their capacity for automated data collection of clinical care indicators, a national challenge. Their choice was not influenced by a quality strategy. Therefore, they cannot be assumed to be comprehensive or the most important measures of quality. The contents of the Quality Dashboard should be reviewed frequently and should be in line with the hospital quality strategy once it is developed.

Another challenge for the project team was in terms of communication with the Board. The project group provided comprehensive information to the Board each month. The time frames required for preparation and delivery of information to the secretary were challenging for the team, and going forward this will need to be planned for. Another challenge was that the team did not always see the agenda in advance of the meeting.

While there was evidence of strong communication between the Board and Executive, and the Executive and clinical staff, this project provided an opportunity for greater transparency and defined channels of communication directly between the Board and staff. It is important for staff to hear from the Board directly and be aware of what the Board requires in terms of information, what discussions and direction the Board is providing on the quality of clinical care, and when the Board recognises the good work undertaken by staff.

Contrary to the recommendation in the HIQA report of the Tallaght hospital investigation the experience gained during this Board QI project highlights the merits of having both Non-Executive and Executive members of the Board. Executive and Non-Executive Directors of the Board undertook training together in order to ensure that Non-Executive Directors have strong skills to enable them to provide objective assessment of the hospital's performance and to hold Executive members to account for delivering that performance.

7 Recommendations

In undertaking this project, the group reviewed the international literature, examined the practices of internationally recognised leaders in quality of clinical care and spoke with a number of international experts. All Board members were also interviewed.

Below are recommendations arising from phase one of the project which were endorsed by the Board for implementation in the near and longer term, as resources become available.

No.	Recommendation	Implementation Plan
Improve information provided to the Board on the quality of clinical care		
1	Review the Board of Directors' Quality Dashboard in line with the corporate strategy, once it is developed.	
2	Ensure that all priority areas of clinical care are reported, e.g. medication safety, antibiotic prescribing, patient experience time in emergency department, transfers during stay, and where information does not yet exist, put in place a plan to get the information. Review the dashboard on an ongoing basis to ensure it is relevant.	
3	Develop the Board of Directors' Quality Dashboard to provide comparisons with peer hospitals and nationally where possible.	
4	Triangulate information on patient safety/ quality of care by using quantitative indicators, together with a range of other sources, e.g. case studies and exit interviews from student doctors and nurses on their clinical placements.	
5	Improve access to information to enable reporting on indicators, i.e. some of the measures initially planned for inclusion could not be collated in a timeframe or format to allow inclusion in the Quality Dashboard for example rates of hospital acquired pressure ulcers.	
6	Automate information collection. Currently the hospital information analyst must manually enter a number of the indicators onto Diveport for inclusion in the Quality Dashboard. Automating this process would be more efficient and reliable.	
7	Expand the Board of Directors' Quality Dashboard to encompass access and finance as well as quality to produce a Board of Directors' balanced scorecard.	
8	Provide the Board with clinical audit reports, with an initial focus on national audits, such as the Quality Assurance programme for histopathology, fractured neck of femur audit, audit of National Early Warning Score (NEWS) and Maternity Early Warning Score (MEWS), HCAI audits and mortality audits where they occur.	
Improve communication and transparency from the Board		
9	Make Board minutes available to staff and the public.	
10	Make the Board of Directors' Quality Dashboard available to staff and the public.	
11	Consider holding Board meetings in public.	
12	Provide defined channels of communication directly between the Board and clinical staff. It is important for clinical staff to hear from the Board directly and be aware of what the Board requires in terms of information, or what discussions and direction the Board is providing on the quality of clinical care directly to frontline clinical staff, including recognition of the good work of staff.	

No.	Recommendation	Implementation Plan
Strengthen the governance of quality and safety through		
13	Provide an induction programme for new Board members.	
14	Progress the establishment of a 'Quality and Safety Board Committee' chaired by a Non Executive Director (see appendix 3 for sample terms of reference).	
15	Review the Mater Board of Directors Code of Corporate Governance to include quality of clinical care within the code and the role of the Quality and Safety Board Committee.	
16	Develop terms of reference for the Board of Directors' meetings, taking cognisance of the positive experience of this project with both Non-Executive and Executive Board members, current Code of Corporate Governance, the HIQA investigations into Tallaght and University Hospital Galway and other relevant national and international reports.	
17	Request Board members to complete a written declaration of interests annually and note at every Board meeting any new relevant conflicts of interest of any member.	
18	Provide an ongoing structured development and training programmes for the Board of Directors on quality of clinical care, including provision of one to one support to Board members should they request it.	
19	Including patient(s) on the Board.	
20	Listen to a patient story or case study at each meeting.	
21	Undertake occasional patient/community meetings.	

7.1 Sustainability

The QI fellows continued to support the project and attended the Board meeting 'Quality Assurance Report' section to measure the impact of the project until December 2014. Following this the project was handed over completely to the hospital. Handover was phased in over two months, i.e. the Mater project lead has assumed responsibility for all aspects of the project. In order to ensure the ongoing sustainability of the Mater Board on Board Project the following was initiated:

- Strong continuing project sponsorship from the leaders in the organisation
- Active leadership for the project from within the Board of Directors' membership
- A project group, including staff undertaking the leadership and quality improvement diploma at RCPI, with the time to develop the relevant information required to support the Board meetings and to develop and implement further change packages
- An ongoing Board development programme to ensure Board members are capable of interpreting information on quality of clinical care so that they can hold the executive to account
- A Board of Directors' induction programme to ensure that new members understand their roles and responsibilities in monitoring and seeking assurance on the quality of clinical care provided
- A mechanism for monitoring the agreed recommendations from this report.

8 Conclusion

This QI project is the first of its kind in Ireland. It was very timely as public hospitals in Ireland are moving to a new governance structure with the establishment of seven hospital groups. Each group will be governed by a hospital group Board. This project, therefore will not only support the Mater in improving its governance of quality of clinical care, but it will also provide an example to other hospitals and other hospital groups. A number of key conclusions are apparent, that are key to spreading this improvement across the health service.

There has been great uptake and support of this project in the Mater Hospital and this bodes well for its ongoing sustainability. Kaplan *et al.*, in their model for understanding success in quality, identify:

1. External environmental factors
2. Organisational leadership and QI capacity
3. The microsystem within which the QI project is occurring
4. The QI project team as the key factors in the success of a project (Kaplan *et al.*, 2011).

All these factors were present in the Board on Board Project:

1. Recent national reports from HIQA recommending actions for Boards
2. The leadership of the CEO and chair of the Board
3. An organisation focused and trained in QI
4. A Board (the microsystem) that recognised the need and participated actively in the project.

In spreading this improvement nationally, while there is the external motivation due to reorganisation of the service, it will be key that within each organisation there is strong leadership and that the Board itself buys into the project.

Importantly in terms of sustainability, this project was supported by a project group, composed of staff and external support from the Quality Improvement Division of the HSE, with both technical and clinical expertise. The project group members were given time out from their other responsibilities to work on the project and were provided with administrative support. This was a labour intensive project. There were twenty two hour meetings in addition to at least the same number of other meetings with stakeholders and staff. The Board members' interviews and analysis were time consuming but absolutely pivotal in ensuring buy in and a project that delivered on the needs of the customer. The time and resource required to do QI cannot be underestimated, particularly a project that is novel, such as this one. This includes the infrastructure and expertise for data collection and interpretation.

There is occasionally a tendency for clinicians to see executives as distant, or even disinterested in the business of caring for patients. However, the literature clearly identifies that the Board is key in setting the direction and culture of an organisation (Conway 2008; Canadian Patient Safety Institute; Millar *et al.*, 2013). It was clear from the interviews of Board members that they do care about patients and providing the best quality of service possible for them: *'Our aim here is excellence in care, in some ways we are a proxy for the patient'* (quote, from semi-structured interview).

However, the Board need both information fit for their purposes of governance *'from a directorial point of view we need sufficient quality of information that we can make reasonably balanced measured decision'* (quote, from semi-structured interview) and they need training and support in understanding the complexities of measures of quality of clinical care. It cannot be expected of Board members, particularly Non-Executive members, who are often not from a clinical background, to understand the complexities of clinical care and its measurement without training. This must be a key focus for newly established hospital group Boards.

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Note: *Monthly targeted reading by Board of Directors

Glossary

Term	Operational Definition
Action	The Board requests follow-up/activity.
Assessment	The interpretation of the information to make an educated conclusion about quality of clinical care.
Benchmark	Is a measure of best performance against which an organisations performance is compared.
Change Package	A specific intervention that has either been demonstrated to or experts believe will positively impact the Board's performance in relation to quality of care.
Clostridium Difficile	Clostridium Difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a C. Difficile infection can range from mild to severe and include diarrhoea, fever and painful abdominal cramps. C. Difficile infection can also lead to life-threatening complications such as severe swelling of the bowel from a build-up of gas (toxic megacolon).
Conflict of interest	Any interest that could result in bias in the work or decision making processes of the Board of Directors.
Driver Diagram	A tool to lay out the various processes that can lead to improved Board action in relation to quality of care. The broad categories of these processes are referred to as Primary and Secondary Drivers.
Chief Executive Officer	The role of the Chief Executive Officer (CEO) is to design, develop and implement strategic plans for the organisation in a safe, cost-effective and time-efficient manner. The CEO is also responsible for the day-to-day operation of the organisation. This includes managing committees and staff as well as developing business plans in collaboration with the Board. In essence, the Board grants the CEO authority to run the organisation. The CEO is accountable to the Chairman of the Board and reports to the Board on a regular basis. The Board may offer suggestions and ideas about how to improve the organisation, but the CEO decides whether or not, and how, to implement these ideas.
Executive Director	A member of a company's Board of Directors who is part of the executive team and is an employee and has a specified decision making role as a director in the organisation.
Health care acquired infection (HCAI)	Health care acquired infection. Infections contracted while receiving healthcare. Staph. Aureus and C. Difficile are amongst the most common. They are a significant cause of ill health, and all practicable measures should be taken to reduce the opportunity for acquiring an infection as a result of treatment and care.
Level of engagement scale	For this project a five point level of engagement scales is used to measure the level of engagement of Board of Directors with quality of clinical care indicators recorded in the minutes or observed at the meeting.
Identify -Situation-Background-Assessment-Recommendation (ISBAR)	A communication tool used in a simple way to plan and structure communication.
Non-Executive Director	A Non-Executive Director (abbreviated to non-exec, NED) or outside director is a member of the Board of Directors of a company who does not form part of the executive management team. They are not employees of the company or affiliated with it in any other way and are differentiated from executive who are members of the Board who also serve or previously served as executive managers of the company. Non-Executive Directors are the custodians of the governance process. They are not involved in the day-to-day running of business but monitor the executive activity and contribute to the development of strategy.
Picture	Visual and numeric presentation of QCC information trended over time.
Recommendation	The Board recommends follow up action by the Executive.
Quality of clinical care (QCC)	Clinical care that is person centred, effective, safe and results in better health and wellbeing.
Quality of clinical care indicator (QCCI)	For the purpose of this project these are (1) Patient experience; (2) Medical readmissions; (3) Surgical readmissions; (4) Staph. Aureus; (5) Cdiff; (6) Hand Hygiene; (7) death in a single room; (8) family room on ward; (9) falls (10) hospital mortality.
Staph. Aureus	Staphylococcal Aureus is a bacteria, often found in the nose or on the skin without causing any symptoms. It can cause a range of infections from a minor boil or skin abscess to life-threatening infections such as septicaemia (infection of the blood) or endocarditis (infection of the lining of the heart).
Understanding	The ability to comprehend the indicators in accessing the quality of clinical care.
Usefulness	Functionality and practicability of indicators in assessing the quality of clinical care indicators.

Toolkit

Resource 1: Board on Board QI Project Semi-structured interview guide

Resource 2: Criteria for selection of quality of clinical care indicators

Resource 3: Quality Dashboard ISBAR prompt sheet

Resource 4: Guide for writing an ISBAR report for Board of Directors' Quality Dashboard

Resource 5: Sample Board of Directors' Quality Dashboard

Resource 6: Quality of Clinical Care Indicators: descriptors

Resource 7: Template agenda for Board of Directors' meeting

Resource 8: Guidance and template for Board of Directors' declaration of interests

Resource 9: Template for Board of Directors' meeting minutes

Resource 10: Sample Board of Directors' monthly survey form

Resource 11: Outline for Board of Directors' workshop

Resource 1: Board on Board QI Project Semi-structured interview guide

Introduction and Welcome

- This is the interview discussed at the last Board meeting for the Mater Board on Board Project.
- The purpose of the interview is to ask about your *views and needs* in relation to the quality of clinical care information provided at Board meetings.
- This is *not a test* for you or the Board, we are checking to see how the Board on Board Project can improve the *communication process*.
- The interview will take approximately *fifteen minutes* (12 short questions).
- Just to confirm we will be *recording* the discussion; is this OK with you?
- We won't be using *your name* on anything. When we write up our findings we will take care to present them in a way that does not identify you or your position.

Questions (adapted and supplemented with follow-up questions as appropriate)

Starting with questions in general

1. As a member of the Mater Board of Directors - what are you *most proud of*?
2. What do you think the Board of Directors *could improve on*?
3. What do you think is the *biggest risk* for the hospital?
Prompt if needed: Is there something that keeps you up at night?
4. What *words* would you use to describe 'quality of clinical care'?

Is the picture/information on quality of care useful? (series of yes / no questions)

5. Is the verbal report you receive (every two out of three months) from executives *comprehensive*?
a. How could it be improved?
6. Is the quarterly written report (Board pack) received every third month *comprehensive*?
a. *Did you get enough time to read the Board report?*
b. If not comprehensive, *how could it be improved? (Can you make suggestions on what could be included?)* (Prompt if needed: *Does it include information on all important aspects of quality of clinical care?*)
7. Is the information presented in a way that is *easy to understand*? **Yes / No**
a. If no, *why not/and how could it be presented better?*

Prompts: graphs, colours, size of print, information on trends over time, benchmarking against other hospitals, RAG ratings (red, amber, green), targets, patient stories to support the data.

Decision and actions

8. Do you think quality of clinical care gets enough *time at Board meetings*? **Yes / No**
a. If no, *why do you think this is the case?*
9. Is there a *culture of questioning* at Board meetings? **Yes / No**
a. If Yes: *Does this extend to quality of clinical care?*

Concluding questions

10. How do you think this *project might support the Board's focus* on quality and clinical care?
11. The project group were wondering if you might consider any of the following useful?
- a. workshop on quality measurement and use of indicators **Yes / No**
 - b. tailored one-to-one session **Yes / No**
 - c. booklet/resources on how to interpret and use indicator information **Yes / No**
 - d. quality and safety walk-round with staff **Yes/No**
12. Do you have any *other comments or suggestions*?

Demographic Questions:

Position (tick relevant box)

☐ Non-executive

☐ Executive

Thank you for your participation

Resource 2: Criteria for selection of quality of clinical care indicators

Project group proposal to Project Sponsors and Board of Directors

The ten quality of clinical care indicators (see Table 1) will be presented and discussed in the 'quality' section of the Board meeting by December 2014. Guidance in relation to 'Boards on Board' advises that the Board should focus its attention on high level outcome measures. Therefore the emphasis is placed on outcome indicators, with process indicators where they support the outcome indicator.

The presentation of indicators will occur in a stepwise approach, with every month building on the previous month. Presentation will consist of an indicator report (designed based on identified requirements of Board Members) circulated with Board Papers and an explanation at Board meeting (using the ISBAR format Identify, Situation, Background, Assessment and Recommendation). Indicators were chosen based on their performance against criteria developed by the project group (①data available monthly, ②data readily accessible, ③data current, ④local importance, ⑤national requirement, ⑥data robustness, ⑦metadata available, ⑧target availability, ⑨ability to benchmark.

Project execution

1. April: Outline of indicators. Also, a summary of: (i) themes identified at interview (ii) measures from reviewing previous Board minutes (iii) review of Board practices internationally.
2. May: (1) Patient experience; (2) Medical readmissions; and (3) Surgical readmissions
3. June: (1) Patient experience; (2) Medical readmissions; (3) Surgical readmissions; (4) Staph. Aureus; (5) C. Diff; (6) Hand Hygiene; and (7) antibiotic consumption (insufficient information for inclusion)
4. July: (1) Patient experience; (2) Medical readmissions; (3) Surgical readmissions; (4) Staph. Aureus; (5) C. Diff; and (6) Hand Hygiene; (7) medical and surgical length of stay (balancing measures). Also, a presentation and discussion by Board on kick start phase of project.
5. September: (1) Patient experience; (2) Medical readmissions; (3) Surgical readmissions; (4) Staph. Aureus; (5) C. Diff; (6) Hand Hygiene; (7) medical and surgical length of stay; (8) end of life care; and (9) falls
6. October: (1) Patient experience; (2) Medical readmissions; (3) Surgical readmissions; (4) Staph. Aureus; (5) C. Diff; (6) Hand Hygiene; (7) medical and surgical length of stay; (8) end of life care; (9) falls; and (10) smoking cessation
7. Following interviews with the Board of Directors (April 2014) and discussion with the CEO it was agreed that mortality indicators (specifics to be agreed) will be reported to the Board in phase two of the project.
8. November/December : review of project, sustain and handover.

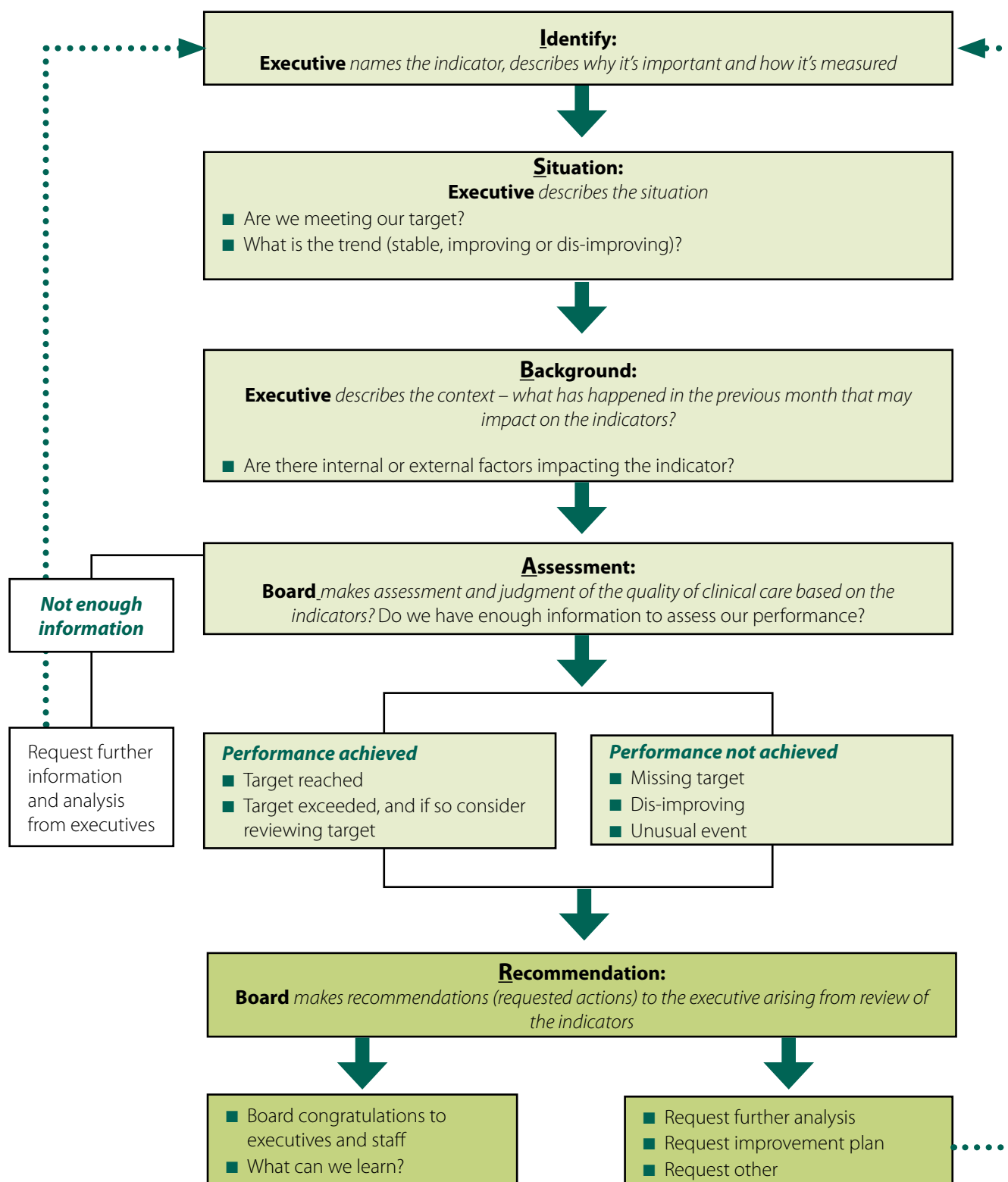
Table 1: Proposed Indicators

	Indicator	Process or Outcome	① Data available monthly	② Data readily accessible	③ Data current	④ Local Importance	⑤ National Requirement eg HIQA HSE	⑥ Data Robustness	⑦ Metadata Available	⑧ Target	⑨ Ability to benchmark	Data available from	Quality Domain (HIQA)
1	Patient experience: Percentage composite score of 16 measures of patient experience of nursing care *	Outcome	Monthly from Feb '14	Yes	Yes	Yes	NSP	Yes	Yes	>90%	Yes	Nursing Department	Patient centered care and support
2	Percentage of emergency readmissions for acute medical conditions to the same hospital within 28 days of discharge	Outcome	Yes	Yes	Yes	Yes (H)	NSP	Yes	Yes	<8.6	Yes	Diveport	Effective care and support
3	Percentage of surgical readmissions to the same hospital within 30 days of discharge after surgery	Outcome	Yes	Yes	Yes	Yes	NSP	Yes	Yes	<3	Yes	Diveport	Effective care and support
4	Hospital acquired Staph. Aureus bacteraemia per 10,000 occupied bed days	Outcome	Yes	Infection per 10,000 bed days utilised	Yes	Yes (H)	NSP/HIQA Requirement of National Director Acute Hospitals from 1 st April 2014	Yes	Yes	Not set	Yes	Infection Prevention and Control Department	Safe care and support
5	Hospital acquired new cases of C Difficile Infection per 10,000 occupied	Outcome	Yes	New cases per 10,000 bed days utilised	Yes	Yes	NSP/HIQA Requirement of National Director Acute Hospitals from 1 st April 2014	Yes	Yes	<2.5 new cases per 10,000 bed days used	Yes	Infection Prevention and Control Department	Safe care and support
6	Hand hygiene: Percentage of clinical staff trained in hand hygiene practices year to date	Process	Yes from Jan '14	Yes	Yes	Yes	NSP and HIQA Requirement of National Director Acute Hospitals from 1 st April 2014	Yes	Yes	100% annually (hospital target. HIQA target is 100% every 2 years)	Yes	CNS.	Safe care and support
	Audit	Process	No	Yes (may use local excel rather than wait for report)	Oct '13 and May '14	Yes	Requirement of National Director Acute Hospitals from 1 st April 2014	Yes	No	90% Compliance of staff with WHO 5 moments of hand hygiene audit tool	Yes	ICN	
7	End of life care: Die in single room	Process	Yes	Yes	Yes	Yes	Yes	Yes	Yes	75%	No	Palliative Care Dept	Patient centered care and support
8	End of life care: Relative room available in each ward. Score against the HSE / HFH Design and Dignity Standards for Family Rooms.	Structure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Room on each ward	No	Palliative Care Nurse	Patient centered care and support
		Structure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Score of 5 against HSE/HFH design and Dignity standards			
9.	No. of Patients who have a new fall per month (rate graded as per risk matrix impact table per 1,000 days)	Outcome	Yes	Yes	Yes	Yes	DOH	Yes	Yes	No	No	Falls Prevention Nurse	Safe care and support
10	In hospital mortality rate: measure to be agreed	Outcome	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	Effective care and support

* patient experience measures in relation to *nursing care* include (listed as per question sequence): Consistent delivery; Patients' confidence; Sense of safety; Patient involvement; Assistance with nutrition & hydration; Hand hygiene; Time spent; Respect & dignity; Support for patients to care for themselves; What is important to the patient; Privacy; Environmental hygiene; Responsiveness; Planning for discharge; quality of care.

Resource 3: Quality Dashboard ISBAR prompt sheet

From May 2014 the Board of Directors received and monitored a *Board of Directors' Quality Dashboard* comprising quality of clinical care indicators incrementally introduced over the months May to November 2014. ISBAR has been introduced across the Irish Health System in 2012 as the communication system for the deteriorating patient. For this project the Board use ISBAR as a useful way to structure the Board discussion around the *Quality Dashboard*.



SBAR, an acronym that stands for: Situation, Background, Assessment, Recommendation, is a technique used for prompt and appropriate communication in the health care organisations. It is modelled upon naval military procedures and was adapted to health care by Michael Leonard, Doug Bonacum, and Suzanne Graham of Kaiser Permanente (Velji, et al., 2008).

ISBAR (Identify -Situation-Background-Assessment-Recommendation) technique is a simple way to plan and structure communication. It allows staff an easy and focused way to set expectations for what will be communicated and to ensure they get a timely and appropriate response (HSE, 2012)

Resource 4: Guide for writing an ISBAR report for Board of Directors' Quality Dashboard

ISBAR is a useful way to structure the report accompanying the Board of Directors' Quality Dashboard. This algorithm outlines the approach to be taken in writing an ISBAR report for relevant quality indicators presented on the Quality Dashboard. The Board of Directors comprises of those with clinical and non clinical backgrounds. This report should be written in language that those with non clinical background can understand.

Identify:

Name and define the indicator being discussed, explain how it is measured, state why it is important (from different perspectives e.g. patient, staff, management). State how the target has been chosen e.g. is it related to any regulation, clinical care programme, national KPI, National QI Programme or policy.

Situation:

- What is the indicator status this month? State if we are meeting our target?
- What is the trend in the indicator? Look at the trend graph for the last twelve months and the activity chart for this year to date compared with the same period last year to date.
- Is our performance (i) stable; (ii) improving; or (iii) disapproving?

Background:

What is the context – what is impacting on the indicator results you are presenting in the Quality Dashboard?

Where applicable, consider including some of the prompts below;

- Are there internal or external factors impacting the indicator, e.g. developing a new service, opening beds, closing beds, national developments, community developments?
- Are there identified improvement plans/projects in progress in the hospital e.g. service improvement plans, business cases, lean projects?
- Have the improvement actions identified relating to this indicator been fully implemented, if not why? Would they have impacted this indicator result?
- Outline any other information that influences the indicator.

Assessment:

What is this indicator result telling the Board about the quality of care provided to patients?

Not enough information

Outline what further information is required and if this information is accessible

Performance achieved

- Target reached
- Target exceeded, and if so consider reviewing target

Performance not achieved

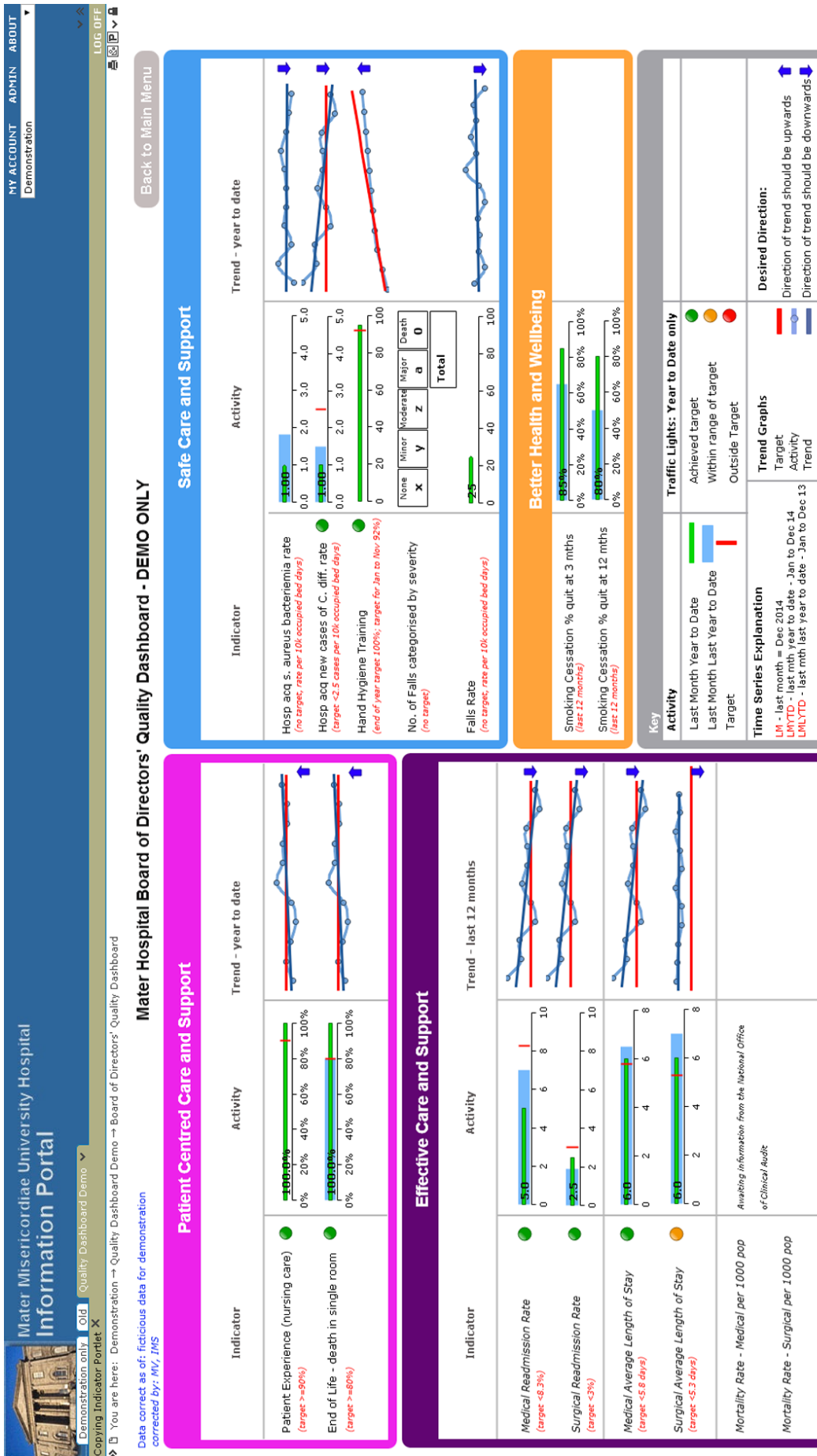
- Missing target
- Dis-improving
- Unusual event

Recommendation:

Board makes recommendations (requested actions) to the executive arising from review of the indicator

- Suggest some actions that the Board might request of the executive in order to improve or sustain this indicator.

Resource 5: Board of Directors' Quality Dashboard (sample data)



The information contained in the dashboard is fictitious and generated for demonstration purposes

Resource 6: Quality of Clinical Care Indicators: descriptors

Quality Domain: Patient centered care and support

Quality Indicator: Patient Experience of Nursing care

Indicator:	Description:	Rationale:	Calculation	Target
Patient reported experience of nursing care	Randomly selected* inpatients asked to complete anonymised patient experience survey during their inpatient stay	<ul style="list-style-type: none"> This indicator provides an insight into the patient's perception of the care provided by nursing professionals' The questionnaire is designed to drive recognition for outstanding experiences and also to identify areas for improvement 	<p>Percentage composite score of 16 measures of patient experience of nursing care</p> <p>Denominator number of wards participating in programme</p> <p>Numerator the sum of the scores for each of the participating wards</p>	<p>■ Green: $\geq 90\%$</p> <p>■ Amber between 80% and 89%</p> <p>■ Red $\leq 79\%$</p>

Note: *inclusion/exclusion criteria applied

Quality Indicator: End of Life care- Access to a single room

Indicator:	Description:	Rationale:	Calculation	Target
The proportion of patients who die in a single room	The number of patients who die in a single room, as a proportion of all patients who die in the hospital	Single rooms are a significant indicator of care outcomes at the end of life. MMUH aims to improve the patients and families experience by utilising single rooms at end of life	<p>Denominator number of patients who die in our care</p> <p>Numerator number of patients who die in our care in a single room</p>	<p>Jan- February 2014 70%</p> <p>March – Dec 2014 80%</p>

Quality Domain: Effective care and support

Quality Indicator: Medical Re-Admissions

Indicator:	Description:	Rationale:	Calculation	Target
Percentage of emergency readmissions for acute medical conditions to the same hospital within 28 days of discharge	Unplanned re-admission, 28 days post medical admission to same hospital	While there will always be a portion of patients who will be readmitted to hospital following discharge for reasons that are not to do with clinical care in hospital, a high proportion or trend of increasing readmissions may be an indicator of some weakness within the care system provided. This includes discharge too early due to inadequate discharge planning and handover, or insufficient supports in the community.	<p>Denominator All Medical "live" discharges and day cases</p> <p>Numerator All non-elective inpatient Medical admissions (non-elective/ inpatient status determined by HIPE in line with HSE) within 28 days of a previous "live" inpatient medical discharge or day case</p>	<p>■ Green: $\leq 8.3-8.7\%$</p> <p>■ Amber between 8.7% and 9.1 %</p> <p>■ Red $\geq 9.1\%$</p> <p>Compstat 2014</p>

Quality Domain: Effective care and support

Quality Indicator: Average length for stay for Medicine

Indicator:	Description:	Rationale:	Calculation	Target
The average length of stay (AvLOS) for medicine based on the average number of days patients spend in hospital under a medical speciality	The average number of patient days for an admitted medical patient episode	The AvLOS is a proxy measure for the quality of care received as well as of the efficiency of the hospital. A low average length of stay reduces hospital costs and can reduce risk of health care acquired complications. However, there is a risk, that in order to deliver efficiencies, patients are discharged too early, or with inadequate follow up in the community, and therefore risk of poor outcome. AvLOS should be reviewed with readmission rates and other quality indicators.	Denominator All medical inpatient discharges Numerator All bed days for medical inpatient discharges	< 5.8 days Compstat 2014

Quality Indicator: Surgical Re-Admissions

Indicator:	Description:	Rationale:	Calculation	Target
Percentage of surgical readmissions to the same hospital within 30 days of discharge	Unplanned re-admission, 30 days post acute or elective, inpatient or day-case surgical admission to same hospital	While there will always be a portion of patients who will be readmitted to hospital following discharge for reasons that are not to do with clinical care in hospital, a high proportion or trend of increasing readmissions may be an indicator of some weakness within the care system provided. This includes discharge too early, due to inadequate discharge planning and handover, or due to poor supports in the community.	Denominator All surgical "live" discharges and day cases Numerator All non elective inpatient surgical re-admissions (non elective/ inpatient status determined by HIPE in line with HSE) within 30 days of a previous "live" inpatient surgical discharge or day case	■ Green: <= 3.00-3.15% ■ Amber between 3.15% and 3.30 % ■ Red >=3.30% Compstat 2014

Quality Indicator: Average length of stay for Surgery

Indicator:	Description:	Rationale:	Calculation	Target
Overall AvLOS for all surgical inpatient discharges and deaths	The average number of patient days for an admitted surgical patient episode	The AvLOS is a proxy measure for the quality of care received as well as of the efficiency of the hospital. A low average length of stay reduces hospital costs and can reduce risk of health care acquired complications. However, there is a risk, that in order to deliver efficiencies, patients are discharged too early, or with inadequate follow up in the community, and therefore risk of poor outcome. AvLOS should be reviewed with readmission rates and other quality indicators.	Denominator All surgical inpatient discharges Numerator All bed days for surgical inpatient discharges	< 5.3 days HSE National Service plan 2014

Quality Domain: Safe Care

Quality Indicator: Hospital Acquired Staph Aureus Bacteraemia

Indicator:	Description:	Rationale:	Calculation	Target
Hospital acquired Staph. Aureus bacteraemia per 10,000 occupied bed days	The total number of cases of Staph Aureus blood stream infection each month reported as positive from a laboratory report on samples taken more than 48 hours after admission, divided by the total number of patient bed days	Staph. Aureus infection contracted while receiving healthcare is a significant cause of ill health and is an indicator of clinical practice	Denominator 10,000 bed days used Numerator Cases of laboratory confirmed positive blood culture of Staph Aureus from a patient who had been in hospital for 48 hours or longer	No target set nationally. Hospital may set its own target.

Quality Indicator: Hospital Acquired C.difficile

Indicator:	Description:	Rationale:	Calculation	Target
Hospital acquired C. difficile cases per 10,000 occupied bed days	The total number of C.difficile cases each month reported as positive from a laboratory report on samples taken more than 48 hours after admission, divided by the total number of patient bed days	C. difficile is a potentially preventable healthcare associated infection that causes significant morbidity and mortality. It has caused a number of significant outbreaks in hospitals and long term care facilities. Rates are linked to antibiotic prescribing patterns and infection prevention and control procedures	Denominator 10,000 bed days used Numerator data All first positive cases of C. difficile associated with diarrhoea in acute hospitals where onset of symptoms was at least 48 hours after admission to acute hospital or with onset within 4 weeks of discharge from hospital	<2.5 Determined by HSE National Service Plan 2014

Quality Indicator: Hand Hygiene Training

Indicator:	Description:	Rationale:	Calculation	Target
Percentage of clinical staff trained in hand hygiene practices year to date	Proportion of clinical staff who have undertaken e-learning or onsite training in hand hygiene year to date	The single greatest prevention for the spread of infection is correct hand hygiene practices. All healthcare staff that interact with patients should receive hand hygiene training every two years.	Denominator: Number of clinical staff Numerator data Number of clinical staff trained year to date	MMUH target 90-100% by year end (8.3% monthly) National target 100% trained over a rolling 2 years

Quality Domain: Safe Care

Quality Indicator: Hospital Falls Rate and Number of Injury Related Falls

Indicator:	Description:	Rationale:	Calculation	Target
1. The falls rate is reported as a rate per 1,000 bed days of care (BDOC)	A patient fall is defined as an unplanned descent to the floor, ground or other lower level with or without injury to the patient	The main purposes of the patient falls indicator, at present, are to; 1. Determine the rate at which patients have a fall	Denominator 1,000 bed days used	No defined target set nationally. Hospital may set its own target
2. The number of injuries categorised as None, Minor, Moderate, Major, Death as a result of a fall	The level of harm caused as a result of a fall	2. Determine the severity with which a patient's fall results in harmful injury	Numerator total number of reported patient falls	

Quality Domain: Better Health and Wellbeing

Quality Indicator: Smoking cessation Quit Rates at 3 and 12 months

Indicator:	Description:	Rationale:	Calculation	Target
Number of patients who engage in the hospital programme and remain quit at 3 and 12 months	The total number of patients who engaged in the programme each month and remained quit after 3 and 12 months	We have a responsibility to manage the health needs of patients and ensure that they have the education, skills, support and access to services that they require to enable better health outcomes. Best practice recommends delivering a 12 month programme	Denominator Total number of people who agreed to participate in the smoking cessation programme Numerator Number who remain quit at 3 months and at 12 months	No target set nationally Hospital may set its own target

Resource 7: Template agenda for Board of Directors' meeting

Board of Directors' Meeting Agenda

Location: [XXXX] Room
Date: [XXX]
Time: 16.30-19.30

No + Ref	Time	Title	Lead	Board Objective ¹	Paper Verbal
		Welcome and introductions	Chairman	To listen	Verbal
1 010714	16.30	Presentation [insert details]	Guest	To listen and discuss	Paper
2 020714	17.00	New declaration of interests	All	To note	Verbal
3 030714	17.05 5mins	Minutes of previous meeting	Chairman	To approve	Paper
4 040714	17.40 20mins	Update on matters arising and review of recommended actions	Chairman	To note	Verbal
5 050714	17.30 45mins	Quality and Safety Report 5.1 Quality Dashboard 5.2 Clinical Directorates Report 5.3 Medical Executive Report 5.4 Nursing Report 5.5 Mission Effectiveness Report 5.6 Quality and Safety Board Committee Report	CEO Lead CD Chair DON Dir Mission NED	To make recommendation	Paper Paper Verbal Verbal Paper Verbal
6 060714	18.15 30mins	Chief Executives Report 6.1 Strategic direction – Hospital strategy – Transformation plan 6.2 Strategic initiatives – ICT – Clinical developments 6.3 Access – Scheduled care – Unscheduled care	CEO	To make recommendation	Verbal and paper
7 070714	18.45 30mins	Finance Report 7.1 [insert details] 7.2 [insert details]	Director of Finance	To approve	Paper
8 080714	19.15 10mins	DAMC Report/Hospital Group update	Chairman DAMC	To listen and discuss	Verbal
9 090714	19.25 5mins	Any Other Business	Chairman	To listen and discuss	Verbal

Note 1: The lead submits the paper to the chair/secretary one week in advance of the meeting and indicates using the *Agenda Item Request Template* the objective which might be one of the following: (i) to note; (ii) to listen; (iii) to approve; or (iv) to make a recommendation.

Board of Directors' Meeting Item for Submission to the Agenda

Item for Inclusion on the Board of Directors' Meeting Agenda (may not be required for standing items)

Title of item for inclusion on agenda:

Submitted for meeting on:

Name of authorising Director:

Reason for inclusion:

Note*

Listen

Approve

Make a recommendation

Standing Item**

*Documents for noting where there are no issues which need to be addressed by the Board of Directors, will be circulated for information/feedback as appropriate prior to the meeting and will be listed for noting on the agenda

** These items will be allocated a maximum of five minutes on the agenda and will require a one page summary paper to be submitted prior to the meeting

Minimum time required:

Will there be attendee(s) for this item (If yes, please supply name(s) and contact details):

Brief description/summary of item:

Please list supporting documents for circulation:

Have there been discussions with Chairman/CEO in advance of this meeting (please state):

Signature:

Date:

Resource 8: Guidance and template for Board of Directors' declaration of interests

What are conflicts of interest?

The Institute of Medicine define conflicts of interest (COI) as 'a set of circumstance that creates a risk that professional judgement or actions regarding a primary interest will be unduly influenced by a secondary interest'. Also described as 'a divergence between an individual's private interests and his or her professional obligations such that an independent observer might reasonably question whether the individual's professional actions or decisions are motivated by personal gain, such as financial, academic advancement, clinical revenue streams, or community standing'. The Mater code of conduct (2015: 26) describes COI as:

...to situations in which financial or other personal considerations may compromise or have the appearance of compromising, an individual's ability to make objective decisions in the course of their job responsibilities within MMUH. In our work, we have a duty to put the interest of MMUH before our own. Employees are required to disclose all possible conflicts of interest involving themselves or their immediate family members (spouse, parents, brothers, sisters and children) by completing the Ethics in Public Office form on an annual basis. If you believe a conflict of interest exists or if you have any question about whether an outside activity might constitute a conflict of interest you should contact our Finance Department.

The Code of Practice for the Governance of State Bodies (2001) stipulates that 'the Board should have procedures to monitor and manage potential conflicts of interest of management and Board members' (section 2.7).

The Tallaght Hospital investigation report (HIQA, 2012) recommends that 'there should be a register of interests in place in relation to individuals with potential and/or actual conflicts of interest, in accordance with the requirements of the Ethics in Public Office Act, that includes Board members and employees of the hospital and those with other relevant conflicts of interest. This should be subject to no less than annual review by the chairperson and chief executive' (recommendation 17).

The Mater Misericordiae University Hospital Code of Corporate Governance (2014) stipulates that 'the Board shall have procedures to monitor and manage potential conflicts of interest of management and Board members' (section 1.8) and that 'on appointment of new Directors, the Secretary of the Hospital will provide them with the procedures regarding disclosure of interests of Directors and procedures for dealing with conflict of interest situations information' (section 2.9).

In the context of the work of Mater Board of Directors, a COI is any interest that could result in bias in the work or decision making processes of the Board of Directors.

The Board acknowledges that COI may exist and that to avoid or eliminate them entirely is unlikely to be possible. COI that are identified, acknowledged and appropriately managed will ensure transparent and good decision making by the Board.

Managing a declared conflict of interest

The chair of the Board is responsible for managing COI and the actions required upon declaration of a conflict of interest by a Board member. This will be based on the risk that professional judgement or actions of the member will be unduly influenced by the COI.

Board of Directors' declaration of interests

All Board members are required to declare their interests in connection with their role on the Board.

The declaration of interests are updated:

- At each Board meeting

Interests are recorded on the Boards register of interests, which is maintained by the Board Secretary.

Please circle the statement that relates to you

- I am NOT AWARE that I have any conflicts of interest. I will notify the chair at Board meetings should I become aware of any conflicts.
- I am AWARE that I have conflicts of interest and I have notified the chair of the potential conflicts.

Details of potential conflict

Signature

Printed name

Registration number (if applicable)

Date

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that Board members act in the best interests of the Board. The information provided will not be used for any other purpose.

Resource 9: Template for Board of Directors' meeting minutes

Board of Directors' Meeting Minutes

Date: [insert date]
 Venue: [Insert Room]
 Attendees: [insert details]
 Apologies: [insert details]
 Time: [insert start to finish time]

Item Ref	Item and discussion	Action by
010714	Presentation [insert details] The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
020714	New declaration of interests [insert details]	[insert name]
030714	Minutes of previous meeting The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
040714	Update on matters arising and review of action points The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
050714	Quality and Safety Report 5.1 Quality Dashboard The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
	5.2 Clinical Directorates Report The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
	5.3 Medical Executive Report The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
	5.4 Nursing Report The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
	5.5 Mission Effectiveness Report The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
	5.6 Quality and Safety Board Committee Report [when established] The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
060714	Chief Executives Report 6.1 Strategic direction – Hospital strategy – Transformation plan The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
	6.2 Strategic initiatives – ICT – Clinical developments The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
	6.3 Access – Scheduled care – Unscheduled care The Board [noted / listened / approved / recommended]: [insert details]	[insert name]

Item Ref	Item and discussion	Action by
070714	Finance Report	
	7.1 [insert details]	
	The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
080714	7.2 [insert details]	
	The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
080714	DAMC Report/Hospital Group Update	
	The Board [noted / listened / approved / recommended]: [insert details]	[insert name]
090714	Any Other Business	
	The Board [noted / listened / approved / recommended]: [insert details]	[insert name]

Log of Boards recommended actions for follow up ¹

Agenda item Ref	Recommended action	Who is responsible	Date due for completion	Status ²

The meeting concluded at: [insert details]

Signed:

Date:

[insert details]

Chairman

Note 1: The aim is to complete the loop by reviewing each month that previous decisions and recommendations of the Board were acted on (i.e. not lost from month to month)

Note 2: Status reviewed each month – possible responses include (i) complete (take off the log the following month); (ii) not started; or (iii) ongoing (work being done).

Resource 10: Sample Board of Directors' monthly survey form

Please tick the relevant box in answer to questions 1 to 4

1. The *Board of Directors' Quality Dashboard* is **useful** in gaining insight into the quality of clinical care?

Strongly disagree	1	2	3	4	5	Strongly agree
-------------------	---	---	---	---	---	----------------

The *Board of Directors' Quality Dashboard*:

- 1a) Is **clearly presented**?

Strongly disagree	1	2	3	4	5	Strongly agree
-------------------	---	---	---	---	---	----------------

- 1b) Is useful in understanding how the Mater is performing **against the target**?

Strongly disagree	1	2	3	4	5	Strongly agree
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- 1c) Is useful in understanding how the Mater is performing **over time**?

Strongly disagree	1	2	3	4	5	Strongly agree
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- 1d) Provides me with enough information to allow me understand **what is being measured**?

Strongly disagree	1	2	3	4	5	Strongly agree
-------------------	---	---	---	---	---	----------------

2. I am confident in my **understanding** of the information provided on 'patient experience, medical readmission rates, surgical readmission rates, *Staph. Aureus*, *C. difficile*, hand hygiene and end of life care'

Strongly disagree	1	2	3	4	5	Strongly agree
-------------------	---	---	---	---	---	----------------

3. The **time given** to report and discuss 'patient experience, medical readmission rates and surgical readmission rates, *Staph. Aureus*, *C. difficile*, hand hygiene and end of life care' was adequate

Strongly disagree	1	2	3	4	5	Strongly agree
-------------------	---	---	---	---	---	----------------

Please make any suggestions that would improve the information given to you tonight

(please use back of page for further comments)

4. What is your role on the Board of Directors?
(Tick relevant box)

☐ Non-Executive Director

☐ Executive Director

Thank you for your feedback

Resource 11: Outline for Board of Directors' workshop

Workshop for the Board of Directors on Understanding Quality of Clinical Care Indicators

Date: [confirm date] September 2014

Time: 14.00-17.00 (light lunch provided from 13.15)

Venue: [to be confirmed]

Invitees: Board of Directors and members of the project team

Aim

To support the Board of Directors in understanding and using the *Board of Directors' Quality Dashboard* to hold the hospital executive to account on the quality of clinical care delivered.

Objectives:

At the end of the workshop the Board of Directors will have:

- An understanding of the context within which the Board is working
- An understanding of quality of clinical care indicators
 - *Identity*: of the indicator - the reason it's measured, the unit it's measured in, the target, the desired direction
 - *Situation*: trend over time, variation
 - *Background*: factors that impact on indicators
- The skills to
 - *Assess*: attain assurance on quality of clinical care in order to question and make an assessment on the information presented
 - *Recommend*: make recommendations to the executive directors

Outline Agenda

Time	Topic	Lead
14.00	Welcome and introductions Introduction to the MBOB Project and the workshop	TBC
14.10	Board governance of quality and safety international leading practice and the Irish context -	TBC
14.30	Measurement of quality of clinical care <ul style="list-style-type: none"> – Principles of measurement – what is the question, what are the actions, what can the measure tell us, what can't it tell us, validity, reliability, understanding variation and impact of measurement – Examples from the Mater Board of Directors' Quality Dashboard 	TBC
15.00	The pathway from a patients care to an indicator <ul style="list-style-type: none"> – Patient story (HCAI) – Case study (Patient fall) 	TBC
15.30	Coffee	
15.45	Exercise on using ISBAR at Board meeting to make assessment and recommendations on quality of clinical care <ul style="list-style-type: none"> – People will be divided into three groups (NEDs, EDs and project group members within each group) to examine: <ul style="list-style-type: none"> (i) patient centred care indicators (group 1), (ii) safe care indicators (group 2); and (iii) effective care indicators (group 3) – Each group will be provided with a template ISBAR sheet and the September Board of Directors' Quality Dashboard. 	TBC
16.20	Feedback from each group (five minutes each) Focus on the Boards' recommendation to the executive	TBC
16.40	Preparation for Quality and Safety walk-rounds Opportunity for Non-Executive Directors to get involved	TBC
16.50	Close of workshop <ul style="list-style-type: none"> – Sir Stephen Moss in conversation with Dr. Philip Crowley (UTube) – Completion of workshop evaluation 	

Appendices

Appendix 1: Project initiation document

Appendix 2: Summary report of the visit of Sir Stephen Moss

Appendix 3: Quality and Safety Board Committee

Appendix 1: Project initiation document

Background to Project

The project is a collaboration between the Mater Hospital, the Quality and Patient Safety Division and the Scottish Patient Safety Fellowship Programme. The project follows the Model for Improvement methodology (Langley, Moen et al, 2009).

The CEO and Board of Directors of Mater Misericordiae University Hospital have identified quality improvement at all levels of the Mater as a priority (Day, 2014). By undertaking the 'Mater Board on Board' project, the Board demonstrates their commitment to quality improvement and leading by example, both within the Mater and across the Irish Health System.

Evidence Base

A search of the international literature found:

1. Evidence that Hospital Board's capacity to understand and engage in improving quality is poor (Institute for Healthcare Improvement 2006; Health Foundation, 2013; Canadian Institute for Patient Safety, 2010).
2. International evidence that there is scope for improvement in capacity and capability in Quality Improvement at every level of hospital care, not least at Board of Director level (Rowell et al., 2006; Conway, 2008; Fresko e Rubenstein, 2013; Bream et al. 2013).
3. Evidence that where hospital Boards prioritise quality and lead on improving it, there are meaningful improvements in quality (Heenan, Khan e Binkley, 2010).

Project Description

The aim of the project is that the Board of Directors of Mater Misericordiae University Hospital, individually and collectively, (i) get a comprehensive picture of the quality of clinical care, (ii) have an understanding of same, and (iii) act to hold the hospital accountable on the quality of clinical care delivered.

- By December 2014, the Board of Directors prioritises, discusses, makes decisions and acts in response to quality of clinical care indicator information
- By December 2014, the Board of Directors rate their understanding of quality of clinical care indicators as improved (by a minimum of one level)
- By December 2014, the Board of Directors rate the usefulness of the information on quality of care indicators as improved (by a minimum of two levels)

This will be achieved through the following actions:

- Make the quality of clinical care the number one focus of the Hospital Board of Directors
- Support Board members in identifying the information that enables them to understand the quality of clinical care provided in the hospital (the project group will propose the indicators)
- Provide this information in a format that is fit for the individual and collective purposes of the Board members
- Support the Board of Directors in interpreting the information being active at leading quality improvement and holding services to account for the delivery of safe quality compassionate care
- Improving the flow of communication of quality of care information to and from the Board of Directors
- Improve the quality of clinical care provided by the hospital (longer term).

It is a 'how' project – how to support the members of the Board get information on quality of clinical care that is fit for their purposes, how to interpret it and how to use it to direct and hold the hospital to account. It is not a 'what' project, i.e. the project will use information on quality of clinical care that is already available within the hospital. It is likely that in the future the Board may identify that information on different areas of clinical care are required, but this is outside the scope of this project.

This project is to be seen as the start of a journey, the end point of which is a comprehensive quality profile used by the Board. The current process of examining quality of clinical care, using one discrete set of indicators, can be expanded to all indicators over time. It will show some short term wins by June 2014 and further by December 2014

Project scope includes:

- Determining the Board's needs and concerns in terms of assurances on the quality of clinical care
- Making proposals / recommendations to the Board based on their feedback
- Ensuring information provided will help with direction and decision making
- Supporting the Board in understanding quality of clinical care
- Changing the process of information being reported to the Board in order to fit their identified requirements
- Improving the communication from the Board on information received.

Project scope excludes:

- Development of new indicators
- Safety indicators
- Quality in the broader sense
- Extending customer to the Board of governors or executive management team.

People:

The customer for this project is the 14 Board members and Board secretary.

The project is led by an internal project team to support implementation of the initial project and to enable sustainability and further development of project aim.

Stakeholder analysis indicates that for the purposes of the project the key stakeholders are the Executive Management Team who provide the information to the Board.

The key components are:

- Identification of suitable quality of clinical care indicators
- Working with the members of the Board of Directors to identify their views needs and concerns through semi-structured interview with each Board member
- Developing an education plan to fit the Board requirements
- Developing fit for Board purpose information on quality of clinical care indicators.

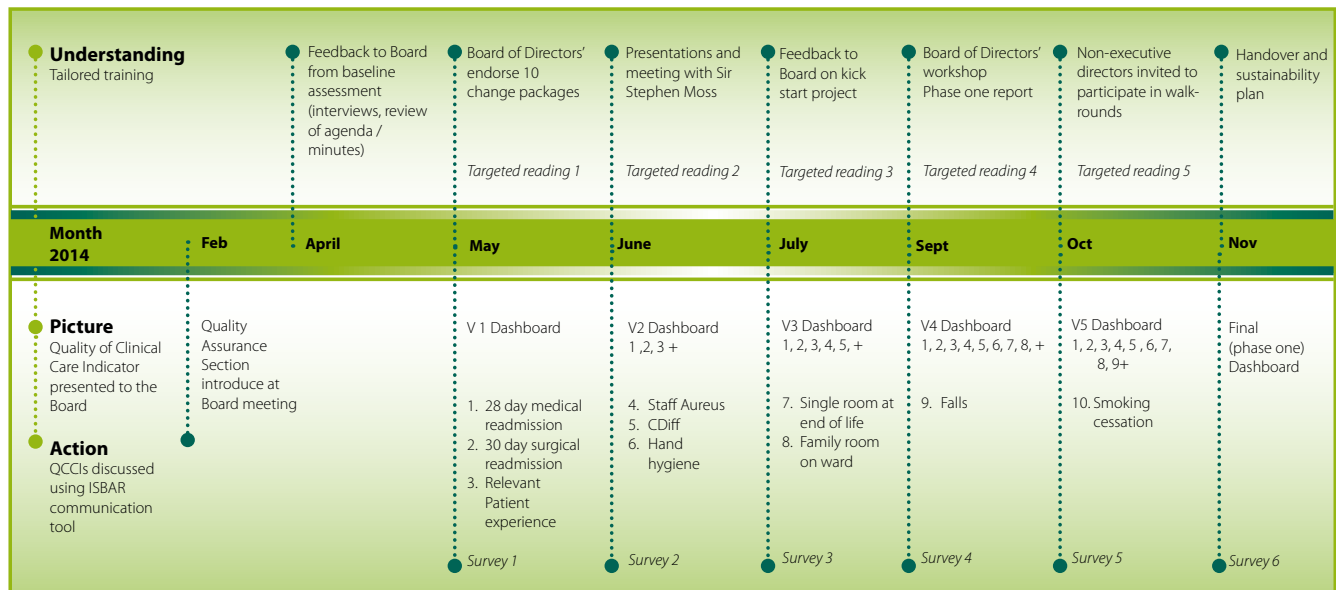
Project Deliverables:

The main deliverables for this project:

- Quality of clinical care is the first or second agenda item for Board meetings
- Set of quality of clinical care indicators identified
- Monthly report available for these indicators
- Indicators are presented in a format fit for purpose
- Board are suitably enabled to use this information to inform their decisions impacting the quality of clinical care delivered
- Board communicates and directs the system based on this information.

Project Measures:

The project objectives detail the success criteria of the project. The list of project measures are outlined in the project measurement plan.

Project Timeline:**Project Quality:**

- The project planned for completion by December 2014 with progress report in July 2014
- Executive Sponsors are CEO and Clinical Director
- An internal project manager has been selected to drive the project
- All project meetings have been scheduled
- The methodology for the implementation of the project is the 'Model for Improvement'
- The project has key measures to identify its success.

Project Cost:

- No direct cost to the implementation of the project.

Project Boundaries:

- It is focused solely on quality of clinical care indicators and not on other aspects of the Board business
- Attendance of project team members at Board meetings are solely for the quality section of the meeting
- Project must use the data already available for the selected quality of clinical care indicators.

Project Assumptions:

The following assumptions have been made

- The Board members will participate fully in the project
- The project team members will participate fully in the project
- MMUH will facilitate the external project group members in accessing all relevant information for the purposes of the project.

Project Constraints:

- The initial kick start project must be reported by June 2014 and completed by December 2014
- Clinical indicators selected must have data that is readily available.

Project Acceptance Criteria:

The following are acceptance criteria

- The project is in keeping with the hospitals mission, vision and values
- Project is owned by the MMUH
- Information obtained by the external project group members during the course of the project remains the property of the MMUH
- The project and recommendations presented and available to the Board by July 2014 Board meeting and completed by December 2014.

Project Communication Plan

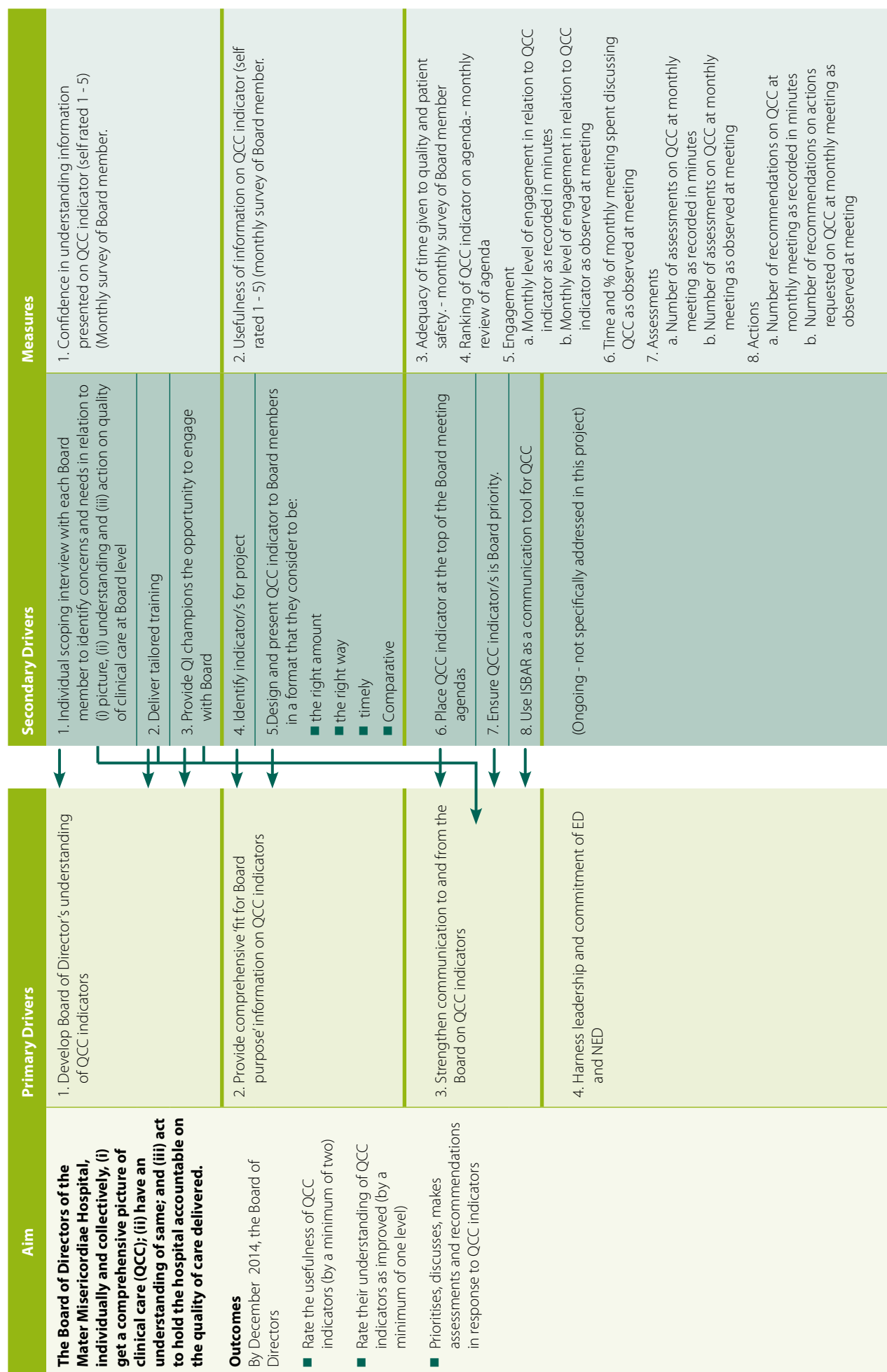
ID	Stakeholder	Action	Schedule
	Board	<ul style="list-style-type: none"> Initial project introduced to Board by CEO Meeting with CEO and briefing paper to Board 	Dec 2013 Jan 2014
		Initial project meeting with Chair & Vice Chair	Feb 7 th 2014
		Attendance by members of project group to each Board meeting	Monthly from Feb to July 2014
		Interview each Board member	March 2014
		Monthly survey	Monthly from March to December 2014
		Final presentation	July 2014
		Board member to join project group	Feb 2014
	Executive Sponsors	Monthly update from Project Manager	Jan 2014
		Attendance at Board meeting	Feb 2014
	Project Group	Fortnightly meeting commenced	Jan 30 th 2014
		Actions card from each meeting	Every fortnight
		Separate meetings with Internal project group members and External project group members	As required
	Collaborators <ul style="list-style-type: none"> Quality Improvement Division, HSE SPSP fellowship 	Sharing of learning from project as opportunity arises	March and June
	Other interested parties: <ul style="list-style-type: none"> Staff Patients Quality & Patient Safety Directorate Dublin Academic Teaching Hospitals/ Ireland East Healthcare in Ireland 	<ul style="list-style-type: none"> CEO update to staff Sharing of learning 	March 2014 to completion of project

Project Risk Analysis

ID	Description of Risk	Prob-ability (1-10)	Impact Rating (1-10)	Result	Impact areas	Preventative action	action
	Project not complete by December 2014	3	9	27	Project Performance Reputation of project group	<ul style="list-style-type: none"> Adhere to project plan Update schedule at every team meeting Schedule monthly meetings 	Provide clear action card for every meeting
	Insufficient data available to enable identification of trends for the Board to interpret	5	9	45	Project Performance	<ul style="list-style-type: none"> Selection criteria for Indicators include frequency of data availability 	Expand date frequency from monthly to quarterly
	Data quality of chosen indicators is not robust	2	7	42	Project Performance	<ul style="list-style-type: none"> Selection criteria for Indicators include clear data specifications, availability for benchmarking 	Include metadata sheets in report
	Project team do not have the time to give to the project	3	8	24	Project Performance Reputation of project group	<ul style="list-style-type: none"> Clear project plan for buy in from project team as to what is required for the project Highlighting to project team the benefits of the project to their future work Realistic time schedules Sign off of work by email 	Having external project members with similar expertise to those in the project team can increase the numbers who can contribute to the project.
	Urgent/competing issues displace MBOB project on the Board Agenda	6	5	30	Project Performance	<ul style="list-style-type: none"> Quality section added to the agenda Commitment from chair to project 	<ul style="list-style-type: none"> Shorten the quality of clinical care indicator section Send information in advance Meet Board members for training outside Board meetings
	Board reject the project	1	9	9	Project Performance Reputation of project group	<ul style="list-style-type: none"> Communicate with Board members and executive sponsors Non executive Board member on project team Interview of Board members as to their needs Monthly attendance at Board meeting to update on project 	<ul style="list-style-type: none"> MMUH Project Sponsors External project members attending each Board meeting

The ratings for both probability and impact are on a 1-10 scale, 1 being of lowest risk, 10 being of highest risk.

Driver Diagram



Operational Definitions

Operational definitions

- Action: The Board requests follow-up/activity.
- Assessment: the interpretation of the information to make an educated conclusion about quality of clinical care.
- Picture: Visual and numeric presentation of QCC information trended over time.
- Quality of Clinical Care (QCC): clinical care that is person centred, effective, safe and results in better health and wellbeing.
- Quality of clinical care indicator: for the purpose of this project these are (1) Patient experience; (2) Medical readmissions; (3) Surgical readmissions; (4) Staph. Aureus; (5) C. diff; (6) Hand Hygiene; (7) Single room at end of life; (8) Falls; and (9) Smoking Cessation.
- Understanding: the ability to comprehend the indicators in accessing the quality of clinical care.
- Usefulness: functionality and practicability of indicators in assessing the quality of clinical care indicators.

Level of engagement scale

Levels	0	1	2	3	4	5
Indicators	Not on the agenda or reported in minutes	In supporting papers but not reported in the minutes	On the agenda and/or reported as presented to the Board	On the agenda and/or reported as discussed by the Board	On the agenda and/or reported as discussed and an assessment made by the Board	On the agenda and/or reported as discussed and a recommendation made by the Board

Note: the operational definitions and engagement scale were revised a number of times (following each PDSA cycle) during the project

Project Measurement Plan

No.	Measure Description	Data Source	Method	Measurement Form	Baseline
1	Confidence in understanding information	Paper Survey	Board Member Self assessment	Likert Scale 1-5.	No
2	Usefulness of information	Paper Survey	Board Member Self assessment	Likert Scale 1-5.	No
3	Adequacy of time given to QCC	Paper Survey	Board Member Self assessment	Likert Scale 1-5.	No
4	Ranking of QCC indicator on agenda	Agenda	Review	Position no. on agenda	Yes
5a	Engagement in relation to QCC indicator	Minutes	Review	Level of engagement scale	Yes
5b	Engagement in relation to QCC indicator	Meeting	Observation through QI fellow attendance at meeting	Level of engagement scale	No
6	% of meeting spent discussing QCC	Meeting	Numerator: Observation by fellows of Quality section of meeting. Denominator: Total meeting time as recorded by secretary	Numerator: time of quality section at meeting Denominator: Total time of meeting	No
7a	No. assessments on QCC indicators in minutes	Minutes	Review	Count	Yes
7b	No. assessments on QCC indicators at meeting	Meeting	Observation through QI fellow attendance at meeting	Count	No
8a	No. of recommendations on QCC indicators in minutes	Minutes	Review	Count	Yes
8b	No. of recommendations on QCC indicators at meeting	Meeting	Observation through QI fellow attendance at meeting	Count	No

Note: learning from this QI project would suggest the likert scale be extended to 1-10 point scale.

Appendix 2: Summary report of the visit of Sir Stephen Moss

Part of the Mater Board on Board Quality Improvement Project involved a visit from Sir Stephen Moss³, to speak with staff and invited guests from our hospital group, the Executive Management Team and Board members. He reflected on his learning through his experience, in asking and responding to what matters to staff and what matters to patients for delivering quality care. There were 4 separate meetings:

1. An introductory meeting was held with the CEO and Executive Management Team, in which he briefly outlined his career and experiences at Mid Staffordshire.
2. Presentation to staff on *How we all matter in delivering quality and safety* – with the aim of sharing experience of quality and safety the Mid-Staffordshire experience. This included top tips for developing a culture of quality improvement. The presentation was followed by question and answer session to over 100 staff and guests from the hospital group, via teleconferencing. The presentation is available to all staff on the Mater internet.
3. Meeting with the Board of Governors and Board of Directors and Board. Commencing with a presentation *Sharing Board experiences of getting Board on Board with quality of clinical care* followed by discussion and exchange of experiences.
4. Meeting with Dr. Philip Crowley, HSE, National Director for Quality and Safety. A video of Dr. Crowley in discussion with Sir Stephen Moss was made – examining the role of Board of Directors in quality and safety and made available on the HSE YouTube channel.

Sir Stephen Moss Presentation/Reflections:

The three key factors, which together led to catastrophic failure

- Professionalism of frontline clinical teams
- Weak governance throughout but particularly at Board level
- Unhealthy culture and ineffective leadership.

How do we know we are as good as we think we are? (assurance)

- Set up systems at every level
- Triangulate the data/intelligence
- Regular testing of systems and their application
- Outcomes versus process
- Embrace challenge – by doing this you make things better
- Visibility – through Board members quality and safety walk-rounds.

Does our culture support safe, effective, compassionate care?

- Are we clear on the role of the Board
- Do we support frontline clinical teams
- Do our values support quality, safe and compassionate care
- Do we provide leadership development
- Do we support our staff to speak out – Board needs to satisfy itself that staff can speak out, this must be more than ‘whistle blowing’
- Do we use human factors science to support development of safety

Remember

- The buck stops with the Board!
- Maintain effective balance between strategy/operational issues 'you can only develop strategy when you have a handle on the operational issues'
- Focus on what matters to patients
- Ensure frontline clinical teams have the tools for the job – hold to account for delivering. Remember staff are human - who on occasions let people down – important we learn from this
- Ensure assurance systems allow you to 'get under the skin' of the hospital (the business of the Board is to seek out assurance – must regularly test the validity and robustness of the system of assurance)
- Celebrate what you do well – but avoid complacency like the plague.

Summary of learning points from discussion with the Board

- Being explicit that 'patient safety trumps all' – this statement was made by the Secretary of State for Health in the UK.
- Undertake a quality impact assessment of all proposed changes.
- Being transparent – Sir Moss spoke of the advantages of opening up the Board meeting to the public and sharing minutes and Board papers on the website. To support this however, criteria for closed Board sessions need to be set to protect personal confidential data or commercially sensitive data being discussed.
- Evaluate effectiveness of Board meetings – ask the media and public are we talking about the things that matter to them and are we spending enough time on this?
- Engage with the media directly – get as much information as possible out there (don't hold anything back). Accept that initially this will lead to some difficult interviews, but this will pass.
- Being aware of apathy or an aspiration to mediocrity.
- Consider the model of 'worry wards' – in order to flag to the Board concerns about potential quality of care issues.
- Focusing on human factors - suggested linking in with the work of Martin Bromley and colleagues on the clinical human factors group.
- Pacing and energy - we have to get braver if something needs to change. In Mid-Stafford Directors accepted some unacceptable situations – knew what needed to change but were not moving fast enough.
- Use the depth of information available from students evaluation of their clinical placements (collaboration with universities/ colleges on this) and from GPs as intelligence on the quality of services.

Sir Stephen Moss is a nurse by background, and has spent his entire career in the NHS. After a number of years in clinical practice, he moved into a variety of nursing and general management roles and has over 30 years experience in posts at Board level, including Chief Nurse, Chief Executive, Non-Executive Director and Chairman. Stephen was appointed by the Secretary of State as a Commissioner on the Board of the first health service quality regulator, the Commission for Health Improvement (CHI). In February 2009, Stephen was asked to join the Board of Mid Staffordshire NHS Foundation Trust as a Non-Executive Director, shortly before the publication of the highly critical Healthcare Commission Report. He took on the role of Chairman in August 2009 until January 2012. Stephen has recently been appointed a Non-Executive Director at Derby Hospitals NHS Foundation Trust.

Appendix 3: Quality and Safety Board Committee

The Health Service Executive (2013) recommends the establishment of a Quality and Safety Board committee, comprising of Non-executive and Executive members, which oversees quality and safety on behalf of the Board. The Quality and Safety Board Committee operates on behalf of, and reports directly to, the Board. The Quality and Safety Board Committee (chaired by a Non-Executive Director) has the following functions:

- oversee the development by the executive/senior management team of a quality and safety programme for the services
- recommend to the Board a quality and safety programme and an executive/senior management team structure, policies and processes that clearly articulates responsibility, authority and accountability for quality, safety and risk management across the services
- secure assurance from the executive/senior management team on the implementation of the quality and safety programme and the application of appropriate governance structure and processes (e.g. risk escalation) including monitored outcomes through quality indicators and outcome measures
- secure assurance from the executive/senior management team that the hospital/community service is conforming with all regulatory and legal requirements to assure quality, safety and risk management
- act as advocates at both Board and Government level for quality and safety issues which cannot be resolved by the executive/senior management team.

The establishment of a Board Quality and Safety Committee has the potential to further support the Board in focusing on quality and safety.



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