

A Board's Role in Improving Quality and Safety

Guidance and Resources



Building a
Better Health
Service

Seirbhís Sláinte
Níos Fearr
á Forbairt

Framework for
Improving Quality
in our Health Service

The logo for the Framework for Improving Quality, consisting of a central blue circle surrounded by several smaller circles in various colors (green, orange, purple, grey).

This resource forms part of a series of resources developed to support services in using the “Framework for Improving Quality in our Health Service”:

- Quality and Patient Safety: Clinical Governance Information Leaflet (February 2012)
- Quality and Patient Safety: Clinical Governance Development: An assurance check for Health Service Providers (February 2012)
- Quality and Safety Prompts for Multidisciplinary Teams (October 2012)
- Safety Pause: Information Sheet (May 2013)
- Quality and Safety Clinical Governance Development Initiative: Sharing our Learning (March 2014)
- National Clinical Programmes Model of Care Development: Checklist Governance for Quality and Safety (October 2014)
- Report of the Quality and Safety Clinical Governance Development Initiative Primary Care: Sharing our Learning (April 2015)
- Board on Board with Quality of Clinical Care: Quality Improvement Project: Case Study Report (June 2015)
- Framework for Improving Quality in our Health Service: Part 1 Introducing the Framework (April 2016)
- Quality and Safety Walk-rounds: A Co-designed Approach Toolkit and Case Study (June 2016)
- Quality and Safety Committees: Guidance and Resources (October 2016)

Copies of the documents above and the resources and recommended reading for each of the board leading practices are available electronically on the website located at www.qualityimprovement.ie.



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Project group: Siobhan Reynolds, Karen Reynolds, Tina Brennan, Anne Marie Heffernan and Maureen Flynn, Quality Improvement Division, HSE.

The terms “patient,” “resident,” “service user,” and “consumer” are used interchangeably in healthcare. Some terms may not be appropriate or preferred when referring to individuals who access healthcare services depending on the care setting or sector. For clarity and consistency, the term “service user” is used throughout this guidance.

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Foreword

I am very pleased to introduce “A Board’s Role in Improving Quality and Safety Guidance and Resources”. This publication provides many illustrative real-world examples of process and outcomes of successful “Boards in Action”. Considering the challenges facing boards, this guidance document offers a practical insight to how boards can develop to discharge their responsibilities for quality and safety in healthcare more consistently in the future. The “Oireachtas Committee on the Future of Healthcare: Sláintecare Report” (2017) recognises the key role of boards and advocates the establishment of healthcare boards. This guidance will assist new and existing boards in using practices which supports positive decision-making, governance and accountability; where service users’ needs come first in driving safety, quality and cultures of person centeredness.

It is written primarily for non-executive and executive members of boards of healthcare providers to support them to perform their role in improving services. Though many examples come from the acute care setting, it is designed for use across all types of healthcare providers, including Hospital Groups, and voluntary HSE funded Section 38 and Section 39 organisations. It may also be useful to providers without boards by making information available to executive management teams and clinical leaders.

This document presents a practical guide to approaches that ensure the quality and safety of service users, staff and healthcare providers alike. It also forms part of a series of resources developed to support the application of the “Framework for Improving Quality in our Health Service” published by the HSE in 2016. This guidance shares international and national perspectives on a board’s role in improving quality and safety by providing examples of leading practices, resources and recommended reading. Our review of the literature has identified many key findings ranging from principles for effective boards and the importance of creating a culture of trust by working together with respectful and robust challenge in achieving high quality care in a sustainable way.

I thank the many staff and board members across the health system that have shared their experiences and made suggestions for strengthening the board’s focus on quality and safety during the consultation processes. I also very much appreciate the considerable commitment and support that the Quality Improvement Division team have given in preparing this document and wish you every success with your board’s journey in improving quality of care and assuring service user safety.



Dr. Philip Crowley
National Director
Quality Improvement Division
Health Services Executive

About This Guidance

There are a number of key documents and resources applicable to boards and executives within healthcare in Ireland. This guidance builds on existing documentation and provides a central repository of international and national perspectives on the board's role in improving quality and safety by providing examples of leading practices, resources and recommended reading.

The resource is hosted on the HSE website and it will be updated to take account of changes in national policies and guidelines and international best practice. The resources and recommended reading for each section are available electronically on the website. This guidance will assist board members to:

- Reflect on their performance and approach to improving quality and safety
- Understand leading quality improvement practices
- Make improving quality and safety a central tenet of a board's agenda
- Develop partnerships with staff and service users for improving quality and safety
- Drive improvements in care in a measurable way
- Be aware of the importance of using proven quality improvement methodologies
- Seek assurance and approve a plan for improving quality and safety.

How was this guidance and resource developed?

This document has been developed with reference to international leading practices which have included a review of relevant publications and material from the UK, USA, Australia, Canada and New Zealand. In addition to the above, the HSE Quality Improvement Division has engaged with Irish and international subject matter specialists in respect of the proposed content.

How to use this guidance?

This guidance is written primarily for non-executive and executive members of boards of healthcare providers to support them to perform their role in improving services. It may also be useful to organisations without boards by providing information to executive management teams and clinical leaders. Reflective questions are provided in each of the sections, related reading and resources for use by board members are located on the relevant web pages located on the "Governance for Quality" section of the Quality Improvement Division website at www.qualityimprovement.ie.

The HSE Quality Improvement Division resources have been prepared in a generic manner and are ready for adaptation in a local context. With regard to other resources, please link with relevant authors regarding adaptation.

Highly engaged Executive Leadership Teams working with highly engaged Boards in a trusting partnership can be the source of will for the entire organisation. As hospitals try to drive rapid improvement, Boards have an opportunity and a responsibility to make better quality of care the organisation's top priority. The Board's responsibility for ensuring and improving care cannot be delegated to the medical staff and executive leadership; ensuring safe and harm free care to patients is the Board's job, at the very core of their fiduciary responsibility. An activated Board, in partnership with executive leadership, can set system level expectations and accountability for high performance and elimination of harm and properly conducted this leadership work can dramatically and continually improve the quality and safety of care.

(Institute for Health Care Improvement, 2008)

Summary of Board Leading Practices in Improving Quality and Safety

1
Leadership for Improving Quality & Safety

Actively demonstrating a commitment to seek assurance and drive improvement

- Board ensures there is a clear vision, goal and strategy for quality and safety.
- Board provides visible leadership in developing a positive culture for the organisation.
- Some board members are recruited with clinical quality and safety expertise.
- Board advises and requests action on quality and safety of care matters.

2
Practices for Improving Quality & Safety

Making quality and safety of care a priority of the boards business

- Board identifies and authorises board terms of reference with a focus on assuring quality and safety.
- Board provides induction and orientation in quality and safety structures for new board members.
- Board prioritises and allocates time on the board agenda to discuss quality and safety.
- Board plans and receives training and development in quality and safety.

3
Partnerships for Improving Quality & Safety

Developing strong collaborative partnerships with staff and service users and the wider community

- Board has the mechanism for direct engagement with service users, staff and wider community.

4
Methods for Improving Quality & Safety

Supporting the provider in applying a quality improvement methodology

- Board approves resources and oversees quality improvement programme selected by the executive.

5
Measurement for Improving Quality & Safety

Selecting board measures to monitor and demonstrate an improvement in the delivery of care

- Board reviews quality and safety information (dashboards, reports).
- Board advises and requests actions for improvement of quality and safety of care.

6
Risk Management & Assurance

Ensuring all risks to service user quality and safety are addressed in a robust and structured way

- Board seeks assurance of quality and safety of care.
- Board monitors and oversees risks to quality and safety of care.

7
Planning for Improving Quality & Safety

Championing and overseeing the development, implementation and monitoring of a plan for improving quality and safety

- Board guides the Executive in the development of Quality and Safety Plan.
- Board approves the Quality and Safety Plan.
- Board supports the organisation in celebrating the key milestones and successes.

Each of the seven leading practices sections describes the rationale, board action and prompts for board consideration.

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Introduction

The National Context

Quality and safety of care has been a major focus over recent years and internationally significant efforts are being made to incorporate this as an integral part of all health systems. The HSE places safety and quality of care at the heart of service provision and delivery (HSE, 2017a). In Ireland, quality in healthcare is defined by the four domains set out in the *National Standards for Safer Better Healthcare* (Health Information and Quality Authority, 2012) i.e. person centred, effective, safe and better health and wellbeing. The overall goal of the HSE quality and patient safety enablement programme as outlined in the *HSE Code of Governance* (2015) is underpinned by four key objectives:

- Services must subscribe to a set of clear quality standards that are based on international best practice
- Services must be safe and there must be a robust level of both quality improvement and quality assurance
- Services must be relevant to the needs of the population
- Patients must be appropriately empowered to interact with the service delivery system.

In 2016, the HSE launched the *Framework for Improving Quality in our Health Service* (HSE, 2016a) which outlines six critical success factors to enable services in achieving a culture that places the person at the centre, reliably delivers safe, effective, equitable, personalised care and continuously seeks improvement. The six drivers in improving quality are: (i) Leadership for Quality, (ii) Person and Family Engagement, (iii) Staff Engagement, (iv) Use of Improvement Methods, (v) Measurement for Quality, and (vi) Governance for Quality.

Governance for quality and safety involves having the necessary structures, processes, standards, oversight and accountability in place to ensure that person centred, safe and effective services are delivered. Good governance supports strong relationships between frontline staff, service users and leaders within any organisation (HSE, 2016a).

Types of Boards in Ireland

Currently in Ireland there are an estimated 500 people participating on healthcare boards. The governing board leads the organisation using authority to direct and control provided by the owner and the legal act of formation (where applicable). They set initial direction and have the authority to act in the service user and services best interest. Governing boards function at arm's length from the operational organisation. They focus on the big picture, are future-oriented and act as a single entity. There are a number of key policy documents and resources applicable to boards and executives within healthcare in Ireland (see Appendix 1 for a summary of policy context). When services do not have boards the CEO / General Manager and executive team take on this responsibility. There are different types of boards within HSE funded healthcare services which operate within the *HSE Performance Accountability Framework* (see Appendix 2). These include:

Hospital Group Boards

Publication of *The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts* (Higgins, 2013) led to the creation of seven hospital groups within Ireland. While the governance for Hospital Groups is currently in development and pending the necessary legal framework for hospital groups to perform their governance and assurance functions, interim arrangements are being progressed to establish Hospital Group Boards within the existing legal framework. Hospital Groups are led by a Group CEO who is legally accountable. These boards are created on a non-statutory basis and have an administrative capacity. During this administrative stage of the reform programme Hospital Group boards have no legal accountability in relation to the Hospital. The sole line of executive accountability for the Group CEO is to the National Director for Acute Hospital Services. The boards are comprised of non-executive directors with executive directors in attendance. Given the scale of these organisations, strong governance arrangements are critical to their success and to quality of care. This guidance document will take account of future arrangements as they emerge.

Voluntary Healthcare Provider Board of Directors (Section 38 and 39)

Many board members are on the boards of HSE funded Section 38 and Section 39 voluntary healthcare providers. These boards comprise of executive and non-executive director members (governance role – integrated corporate and clinical / care governance). Voluntary / non-statutory healthcare providers have a long history of providing health and personal social services in Ireland. These organisations vary in scale and complexity, ranging from large acute hospitals to local community based organisations providing social care services. There are a significant number of Section 38 Agencies - 24 voluntary acute hospitals and 22 social care agencies currently within the HSE Employment Control Framework (HR Circular 019/2017b). Section 39 Service Arrangements cover all voluntary and community agencies, other than the above, in receipt of funding over €0.250m. Traditionally Section 39 agencies have been involved in the provision of disability and social services in Ireland.

Advisory Boards

Some acute hospitals have an advisory Medical Board. It usually comprises of medical doctors who meet monthly / quarterly in an advisory capacity. This arrangement precedes the establishment of clinical directorates and is being changed as structures develop and evolve. Clinical directors lead each directorate and along with the chief clinical director are members of the executive management team.

Why is Governance for Quality and Safety so important?

The first Irish national study of adverse events in hospitals (Rafter et al., 2016) highlights the importance of shifting the focus towards quality and safety of care. A total of 1,574 randomly selected adult inpatient records from a sample of eight hospitals stratified by region and size across the Republic of Ireland in 2009 were retrospectively reviewed. The prevalence of adverse events in admissions was 12.2%, with an incidence of 10.3 events per 100 admissions. Overall 70 % of events were considered preventable. Irish adverse event prevalence is at the upper end of the range of other international studies (3% to 17%). This study quantifies the adverse event burden and provides an incentive to drive quality improvement. Achieving sustainable changes to quality and safety is not easy and requires a strategic, consistent and evidence informed approach at all levels in the organisation.

A report published by HIQA into the governance of patient safety within Tallaght Hospital (HIQA, 2012b) which focused partly on the role of the board, made a number of recommendations. Some of these focus on strengthening the arrangements to hold chief executives and chairpersons to account for the delivery and quality of the service. It also included a requirement for existing boards and executives of all health and social care service providers in receipt of state funds to assess themselves against the relevant recommendations within the report and to modernise the constitutional basis, composition and competency of such boards (HIQA, 2012b). Irish Boards can also learn from the experience in the UK, where Monitor (Independent Regulator of NHS Trusts) highlighted the following areas of consistent failure (Hall, 2012):

- 1. Leadership of quality is weak:** Lack of awareness of quality indicators, lack of discussion and challenge, quality is not adequately prioritised.
- 2. Failure to recognise a problem:** Information provided to the board is insufficient to enable challenge / action (particularly proactive action) issues / risks are not communicated appropriately.
- 3. Lack of assurance and challenge:** Check and challenge of frontline compliance, the board has taken sensible actions but has no assurance process to check they are being complied with, the board has no mechanism to independently assure quality governance.
- 4. Inadequate risk management:** Inability to identify risk for itself and then put it right sustainably, too much reliance on third parties, ineffective risk management, lack of clinical engagement with some or all staff groups.
- 5. Inadequate implementation of policies, procedures, protocols and guidelines:** Confusing the existence of policies, procedures, protocols and guidelines with their appropriate use.

There is a growing literature showing that hospital board activities matter for better, safer patient care (Botje, et al., 2013; Jones et al., 2017; Mannion et al., 2017). Board composition and board practices are found to be important factors related to quality and safety of care (Jiang et al., 2009).

Getting 'Boards on board' in Ireland

The benefit of board leadership in Ireland was recently demonstrated in a quality improvement project 'Board on Board with Quality of Clinical Care' (Mater Misericordiae University Hospital and HSE Quality Improvement Division, 2015). This project had an overall aim that the Board would individually and collectively get a picture of the quality of clinical care. The Board would have an understanding of same and act to hold the hospital accountable on the quality of clinical care delivered.

During the project the board and staff had the opportunity to meet with Sir Stephen Moss, former Chairman of the Mid Staffordshire NHS Trust Board to discuss how boards can ensure that quality and safety are priority agenda items for all board meetings. Based on his experience of leading healthcare boards responding to critical clinical incidents Sir Stephen Moss posed four questions for boards.



Board Considerations

- If there is one lesson to be learnt, I suggest that people must always come before numbers. How is your board making this a reality?
- As a board, how do you ensure the right balance between strategy / operational issues in board meetings, and how do you use operational feedback relating to service user safety and experience to develop strategic intentions?
- How do you proactively seek out the views of the community you serve and how does the board use this intelligence to improve the quality of care?
- How do your board members get the evidence to assure them of the safety and quality of services you provide?

Source: Sir Stephen Moss (2014)

Summary

Boards have a key role to play in the governance of an organisation as accountability for the quality and safety of a service ultimately rests with the board and its executive team. Much of the focus and studies has been on the role of clinicians and management in relation to safety, however the role and influence of boards has not received the same attention. The purpose of this guidance is to support boards of healthcare organisations to explore and understand their role in improving quality and safety.



Leadership for Improving Quality and Safety

“Board leadership is a critical ingredient to achieving better, safer care and governing boards can choose to be either active leaders or passive overseers in the process”

(Bader et al., 2006)

The Board of a healthcare provider has a role in setting out the vision and goals for improving quality and safety. Board members, leaders, managers and clinicians can seek out and use all opportunities to visibly display their commitment to building a culture of quality and safety by actively demonstrating the values of the service, regularly listening to service users and staff, seeking assurance of safety and evidence of the quality of services.

Board Roles and Responsibilities

The *Code of Practice for the Governance of State Bodies* (Department of Public Expenditure and Reform, 2016) provides a framework for the application of best practice in corporate governance by both commercial and non-commercial state bodies. In Ireland, the Public Appointments Service is responsible for the recruitment of members to state boards. It has outlined as part of the recruitment for Hospital Group Boards the chairperson's role in the development and implementation of effective corporate and clinical governance structures, along with oversight of the quality and safety of systems of care in place for service users (Public Appointments Service, 2017a). In order to be an effective contributor on a board it is recommended that members:

- Bring independent and objective scrutiny to the oversight of the organisation;
- Be prepared to be challenging, when necessary, while being supportive to the delivery of strategy and objectives;
- Be equipped to offer considered advice on the basis of sound judgement and experience;
- Be prepared to make a time commitment to their work commensurate with the role;
- Constructively supports and challenges the Chief Executive as to the demonstrable effectiveness of the quality, safety and timeliness of the services delivered;
- Constructively supports and challenges the Chief Executive in the oversight of risk management;
- Provide advice in relation to strategic direction, effective role of the board in collectively leading for quality.

The board comprises across its membership, the necessary skills, competencies and experience to enable it to deliver on the strategic and visionary change management agenda and oversee the provision of high quality safe service user care. The appointment process for members of the Hospital Groups seeks to ensure demonstrable expertise in clinical, business, social, legal, medical academic, nursing and patient advocacy (Public Appointments Service, 2017b). Competencies in clinical governance, quality assurance and patient safety are sought to ensure the correct board skill mix and competencies.

Recent studies reveal a significant and positive association between a higher percentage of clinicians on boards (both as non-executive and executive members) and the quality ratings of healthcare provided, especially where doctors are concerned. This positive influence is also confirmed in relation to lower morbidity rates (Sidorov, 2016; Veronesi et al., 2013). A further study demonstrates that executive nurse / midwife directors, who are members of boards, can provide invaluable advice and support to the board around matters of quality and safety (Jones et al., 2016; Mastal, et al., 2007; Matchell, et al., 2010).

Board effectiveness for improving quality and safety relies on the ways in which board members use their knowledge and the information they receive in overseeing the provider's plans for improving quality (Ninnger, 2011). In order for quality and safety of care to be a priority for the board it is scheduled in a dedicated section of the board agenda to ensure that appropriate attention is given. In many cases, a dedicated board quality and safety committee can be established to review reports of quality of care in greater detail. The roles of the board and the chief executive should be clear around addressing quality concerns and questions. Table 1 outlines the role of the board chair, the chief executive and non-executive and executive members of the board.



Chief Executive Officer and Executive Responsibilities

While this guidance seeks to increase board members' understanding of best practice in improving quality and safety, it is the responsibility of the Chief Executive Officer (CEO) to implement the board's policies in relation to quality and safety and for ensuring quality and safety within the organisation. By providing timely accurate and precise information to the board the CEO ensures the board can carry out their function with regard to governance for quality and safety and to allow it fulfil the safety objectives and functions set out in this guidance document. It is the CEO's responsibility to ensure the board has sufficient information on risk identification, assessment and control strategies and ensures effective systems, procedures and practices are in place in order to evaluate the effectiveness of its operations.

The CEO encourages board competencies and commitment regarding quality and safety, while providing a transparent line of sight between the board and the rest of the organisation. An engaged board plays a key role in organisational culture and safety. Developing and engaging the board is one of the key leadership domains that require CEO focus and dedication to develop and sustain a culture of safety (American College of Healthcare Executives and the National Patient Safety Foundation's Lucian Leape Institute, 2017).

Table 1: Key Governance Strategic Roles

	Chair	Chief Executive	Non-executive	Executive
Formulate Strategy	Ensures board develops vision, strategies and clear objectives	Leads strategy development process	Brings independence, external skills and perspectives, and challenge to strategy	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CEO to account for operations and strategy. Ensures board committee are properly constituted with terms of reference Reports to the owner / shareholder	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for strategy Offers constructive scrutiny and challenge Participates as member of key committees	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected and modelled in their own and in the board’s behaviour and decision making	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected in their own and the executive’s behaviour and decision making	Actively supports and promotes a positive culture. Provides a safe point of access to the board for ‘whistle-blowers’ (protected disclosure)	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour
Context	Ensures all board members are well briefed on external context	Ensures all board members are well briefed on external context		Ensures relevant members of their teams are well briefed
Intelligence	Ensures requirements for accurate, timely and clear information to board / directors are clear to executive	Ensures provision of accurate, timely and clear information to board / directors	Satisfies themselves of the integrity of financial and quality and safety intelligence	Takes principal responsibility for providing accurate, timely and clear information to the board
Engagement	Plays key role as an ambassador, and in building strong partnerships with: <ul style="list-style-type: none"> • Service users and public • Clinicians and staff • Key institutional stakeholders • Regulators 	Plays key leadership role in effective communication and building strong partnerships with: <ul style="list-style-type: none"> • Service users and public • Clinicians and staff • Key institutional stakeholders • Regulators 	Ensures board acts in best interests of the public Senior independent director is available if there are unresolved concerns	Leads on engagement with specific internal or external stakeholder groups

Source: adapted from Rice et al., (2015)



Leadership Behaviours for Improving Quality

Place the quality of patient care, especially patient safety, above all other aims. Engage, empower, and hear patients and carers at all times. Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work. Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

(Extract from the National Advisory Group on the Safety of Patients in England, A Promise to Learn, a Commitment to Act, 2013)

Board members as leaders have the opportunity to be more than champions for improving quality of care; they can be active participants (HSE, 2016a). A board can clearly demonstrate their commitment to quality and safety by collectively leading and influencing the overall culture of the organisation. Maintaining a culture that prioritises quality and service users' safety is a reasonable expectation for highly effective boards.

Boards can channel their efforts towards supporting a culture of learning rather than driving compliance only. Individual and collective board member behaviours can accelerate the organisation's quality journey. The Institute for Healthcare Improvement (IHI) High-Impact Leadership Behaviours: Five Things Leaders Can Do to Promote Improvement (2013) outlines how leaders can examine their own behaviours (see Figure 1 below).

Figure 1: IHI High Impact Leadership Behaviours



Source: adapted from Swensen et al., (2013)

Boards have an essential role in promoting a culture of quality and safety of care through their own behaviours and actions by:

- Setting one large goal for quality and safety for the organisation
- Making quality and safety of care a core part of the board's meeting agenda
- Reflecting the core values of the organisation in the decisions of the board
- Supporting the provider in becoming a learning organisation
- Sharing service user stories at board meetings
- Fostering a culture of transparency and honest communication
- Encouraging and supporting the executive to identify resources for staff education on improving quality and safety
- Supporting the executive in developing the provider's programme for improving quality and safety.



Board Considerations - Role of Leadership in improving Quality and Safety

- How does our board define quality and safety?
- What are our specific targets and outcomes for improving quality and reducing harm? Who can be part of the process to develop those aims?
- Does our board demonstrate our commitment to quality and safety by the actions we take?
- Does our board communicate in a transparent way?
- How does our board invest in the development of staff as leaders for improving quality?
- How does our board 'ring fence' resources for improving quality and safety?





Practices for Improving Quality and Safety

"The capability of boards and board quality committees to function effectively and to move appropriately between fiduciary and strategic modes relies on boards and senior leadership capacity to develop trust and a strong collaborative relationship, while not undermining the board's duty to ask challenging questions."

(Canadian Patient Safety Institute, 2011)

Healthcare providers continuously grapple with execution of effective systems for quality and safety. The development of the “right” strategies to “get the board on board” to improve quality and safety require investment and the implementation of appropriate processes at the board, organisational and clinical levels (Canadian Patient Safety Institute, 2011). Many countries have a statutory duty for boards on ensuring quality is a core part of the main board meetings and discussed in more detail by a quality and safety committee (National Leadership Council for Board Development, 2010; Excellent Care for All Act, 2010). *The Oireachtas Committee on the Future of Healthcare: Sláintecare Report* (2017) recommends a statutory quality and safety committee of the board that may help to organise information and review all material pertinent to quality and safety. Although a board may delegate some tasks, the entire board is still responsible for oversight and decision making around quality and safety (Canadian Patient Safety Institute, 2011).

In Ireland, the HSE (2015) *Code of Governance* section 7 outlines the commitment to service quality, safety and risk management and the commitment to a quality and patient safety enablement function in the HSE. The board establishes the structures to make quality and safety a central tenet on the board’s agenda by:

- Building the board’s capability (knowledge and skills)
- Prioritising board time discussing quality and safety
- Establishing a board quality and safety committee, and
- Evaluating the board’s performance with an emphasis always on quality and safety improvement.

Recent studies suggest that effective hospital governance by boards is related to a hospital’s performance on quality (Millar, et al., 2013; Jiang et al., 2009; Jones et al., 2017; Tsai et al., 2015). Hospitals with a higher level of board attention to quality are likely to have stronger management practices centred on monitoring quality. Understanding the dynamics among healthcare providers’ governance, management, clinicians and regulators offers new opportunities for improving quality and safety (Fresko and Rubenstein, 2013).

Building Board Knowledge and Skills for Improving Quality

Boards bear the ultimate responsibility for everything in a healthcare provider, including quality and safety. To discharge that responsibility well, board members require a solid knowledge base about quality and safety and apply that knowledge in action (McGaffigan et al., 2017; Reinertsen, 2017). As board members may not have backgrounds in healthcare, a comprehensive board induction and mentoring programme will provide support to new board members in their role.

An orientation programme will provide an overview of the organisation and roles and responsibilities of a board member. Assigning a mentor for each new board member is another method of ensuring that board members transition into their role. Organising one-to-one meetings prior to and after board meetings will enable new board members understand the business of the board and the information on quality and safety provided to it.

Ongoing development of individual board member’s knowledge and skills can be achieved through peer support, formal mentoring programmes and more focused training days or master classes. Board development days can provide members with opportunities to learn and work together, and bring the board members, executives and other leaders in the same room (see Table 2 outline of board development). Development days can also foster a shared agenda, as well as enable acquisition of quality improvement skills and knowledge. Board members may value support in the form of discussion forums, action based interventions, and group coaching (Canadian Patient Safety Institute, 2011). The board can create opportunities to learn from other similar boards as organisations can share leading practices and initiatives through existing networks and conferences. “Critical friend visits” using an appreciative enquiry ethos have also been used effectively (Healthcare Improvement Scotland, 2015). Using a board evaluation process to identify what the board perceives as their education requirements will support the development of ongoing programmes (See Resources for sample approaches).



Table 2: Outline of Board Development

- Orientation programmes for new directors with specific references to quality and safety
- Inviting board members to attend key briefings on national policies / regulatory requirements
- Distributing articles and relevant reading material
- Participating in quality improvement programmes with academic partners
- Raising awareness of outside conferences / master classes
- Partnering with similar organisations to organise site visits
- Inviting staff to brief board members on quality improvement initiatives
- Participating in quality and safety walk-rounds across the service
- Meeting with service user forums / councils or panels.

Source: adapted from Bader and O'Malley (2006)

There is an opportunity to establish practices - at board level and committee - that allow board members time to apply their knowledge effectively (see Table 3). This will avoid filling up meeting time sharing information that could easily be read in advance of the meeting, thereby creating sufficient time for board discussion and questioning with the executive (Reinertsen, 2017).

Board Quality and Safety Committee

The board quality and safety committee oversees quality and safety on behalf of the board (See Resources for sample terms of reference, agenda, minutes, and checklist for prioritisation of measures). This group focuses on the organisation's approach to quality and safety (Joint Commission International, 2007). The board quality and safety committee has a role in helping the board to focus its discussions on important opportunities to improve safety and quality across the system (Joint Commission International, 2007). The HSE service agreement with Section 38 and 39 healthcare providers requires them to establish a quality and safety committee of their board (Part one clause 24.6). Part 2 of the agreement describes the committee's function (Schedule 2 quality and safety). The committee terms of reference can clearly set out the responsibility of this committee - to carry out work on behalf of and report to the board.

The committee can carefully select board members with quality / safety expertise from other professions and members of the committee can also learn from clinical staff on the committee through scheduled one-one meetings or walk-rounds in services (HSE, 2016c). The board's quality and safety committee may look at more detailed reports than the full board does. The entire board see the areas that are important to the specific quality and safety objectives / targets. Dashboards can be helpful with a narrative summary of key indicators (Joint Commission International, 2007). Staff can be invited to attend board meetings to present quality improvement initiatives. Service users and family members can give a new perspective on how the provider delivers care and can provide a 'human face' to the care represented by the data presented (Joint Commission International, 2007; Thompson, 2013).

The board quality and safety committee is established to (HSE, 2016b):

- Provide a level of assurance to the board on the appropriate governance; structures, processes, standards, oversight and controls
- Oversee the development by the executive management team of a quality improvement plan for the service in line with an agreed quality improvement strategy
- Recommend to the board a quality and safety programme and an executive management team structure, policies and processes that clearly articulates responsibility, authority and accountability for safety, risk management and improving quality across the service
- Secure assurance from the executive management team on the implementation of the quality and safety programme and the application of appropriate governance structure and processes (e.g. communicating risk) including

monitored outcomes through quality indicators and outcome measures

- Secure assurance from the executive management team that the service is conforming with all regulatory and legal requirements to assure quality safety and risk management
- Consider in greater depth matters referred to the committee by the board and referral of issues to the board for consideration when necessary.

The board quality and safety committee normally consist of a number of executive and non-executive directors (drawn from the board) and service user representatives / advisors. The committee is normally chaired by a non-executive director (member of the board) who reports on behalf of the committee to the chair of the board.

Board Evaluation

Annual evaluation of the board and its operations is a good method to ensure that the board is functioning effectively as set out in the terms of reference and standing orders. When board committees are effective they enable more time to be used at board meetings for discussion and development opportunities. Working committees are the engine that powers effective boards and despite the importance of committees, it is noted that few boards engage in a regular and focused evaluation of their working parts (Canadian Patient Safety Institute, 2011). *The Code of Practice for the Governance of State Boards* (2016) provides a model "Board self-assessment evaluation questionnaire". Board evaluations can take many different forms using external reviewers, surveys of members or facilitated workshops.

Boards with higher levels of maturity in relation to governing for quality improvement (QI) have the following characteristics: explicitly prioritising QI; balancing short-term (external) priorities with long-term (internal) investment in QI; using data for QI, not just quality assurance; engaging staff and service users in QI; and encouraging a culture of continuous improvement; ...enabled and supported by board-level clinical leaders.

(Jones et al., 2017)



Table 3: Embedding Board Disciplines

Competent, systematic board disciplines form the bedrock of good board functioning. The chair gives thoughtful attention to board agenda planning and management to maintain a balance between oversight of operations (including dedicated time for quality and safety) and strategy. Chairs face the challenge of attending to the full breadth of the board's role while ensuring that board meetings do not descend into a gruelling test of board member endurance. The following board disciplines are considered:

- **Board and committee year planners and annual programmes of work:** to ensure a coherent programme for formal board meetings, board seminars and away-days and committee meetings. It is good practice for the work of every committee (including quality and safety) of the board to be shaped by an annual plan.
- **Board papers:** The effectiveness of the board is dependent on the timely availability of board papers.
Timeliness: the board papers provided ideally a week ahead of meetings (including reports and quality of care indicators).
Cover sheets: including, for each paper, the name of the author, a brief summary of the issue, the organisational forums where the paper has been considered (for example executive quality and safety committee), the strategic or regulatory objective.
- **Executive summaries:** Succinct executive summaries that direct the readers' attention to the most important aspects.
- **Action logs:** Boards and committees can be helped to keep track of actions agreed by maintaining and monitoring a log. The log should show all actions agreed by the board and for each action the ownership, due dates and status.

Source: adapted from National Leadership Council for Board Development (2010)



Board Considerations - Practices for Improving Quality and Safety

- Does our board prioritise quality and safety on the board's agenda?
- As a board, do we spend a minimum of 25 % of board meetings discussing quality and safety of care?
- How do we support board members to understand the information presented on quality and safety of care?
- How do we monitor progress towards quality and safety goals?
- What are the ways in which our board evaluates performance on quality and safety?





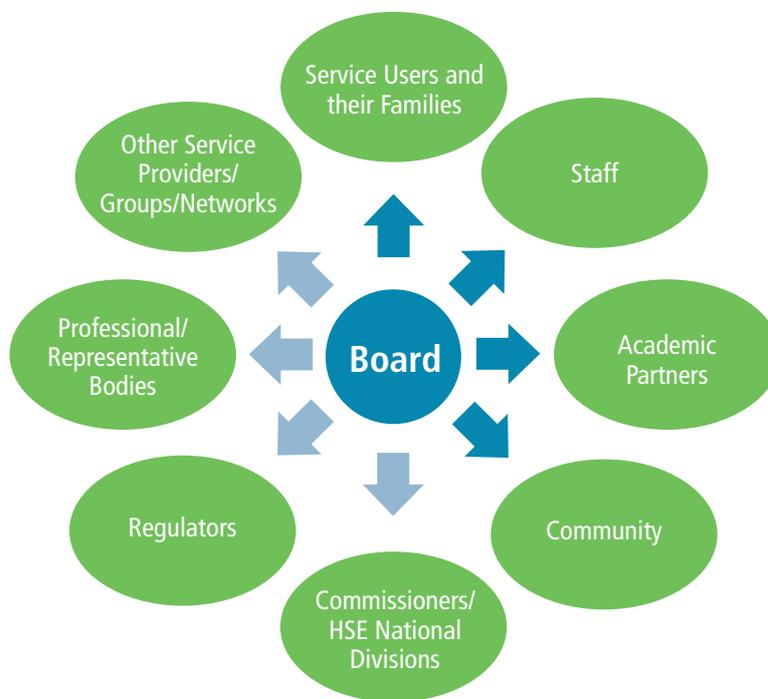
Partnerships for Improving Quality and Safety

“Effective boards give priority to engagement with stakeholders and “Effective boards give priority to engagement with stakeholders and opinion formers within and beyond the organisation; the emphasis here is on building a healthy dialogue with, and being accountable to, service users, the public, and staff, governors and members, commissioners and regulators”

(adapted from National Leadership Council for Board Development, 2010).

The board and management work in partnership to ensure the delivery of safe, high quality care. The perspectives of staff, services users, professional bodies, other service providers and regulators provide insights to how the organisation provides this care. Outlined in Figure 2 are a number of key stakeholders that the board may wish to directly engage with to gain an understanding of the quality and safety of care provided by the organisation they have oversight for.

Figure 2: Key Stakeholder Partnerships for Boards



Service Users and their Families - There are a range of benefits in collecting and using service user and their families' experiences. It helps to improve communication and shared decision-making between service users and staff and informs planning and service improvement. Boards have a role in ensuring that the ethos and culture of the organisation has a focus on person centred care and that the views and suggestions of service users and their families are sought and incorporated in any change to services (NHS Scotland 2016a; Pomey, et al., 2016). Including service user representatives within the board membership along with service user stories as part of the board's agenda supports the board to focus on the service users of the organisation.

In Ireland, we describe person centred care as an "approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives" (McCormack, McCance, 2017). Engaging and involving service users in the design, planning and delivery of all care demonstrates a commitment to person centred care (HSE, 2016a).

Staff - Positive staff engagement is critical to achieving high quality safe care. Boards, directors, managers and clinical staff can develop an understanding of each other's roles and create strong collaborative relationships to achieve the quality and safety objectives set by the provider.

Examples of methods of building board understanding and relationships with staff:

- promoting the 'visibility' of board members via walk-rounds, photos of board members
- holding board meetings in public and circulating board minutes
- meeting staff members who have led on quality and safety initiatives
- seeking assurance from the executive that there are systems in place to obtain staff feedback, e.g. staff exit interviews and student placement reviews.



Staff are engaged when they feel valued, are emotionally connected, fully involved enthusiastic and committed to providing a good service... when each person knows what they do and say matters and makes a difference.

(HSE National Staff Engagement Forum, 2016)

Academic Partners - Boards can work with academic partners to support the overall provider in improving the quality and safety of care by resourcing and facilitating research and innovation in line with overall quality strategic plans. Academic partners can also play a role in designing and providing education programmes for staff and undergraduates that integrate theory and practice in the care environment. The report to the Minister for Health on the establishment of hospital groups recommends the role of a chief academic officer whose role is to bring the academic function to top table decision making (Higgins, 2013). All Hospital Groups have been aligned to Universities who have medical and healthcare faculties within their catchment area. The report also emphasises the importance of academic linkages to focus on the research, innovation, education and training agendas that are so fundamental to improved service user care.

Community - Effective boards are informed by the external context within which they operate. Boards have a role in engaging with the communities they serve. The board has a role overseeing the funding, resourcing and reporting on quality improvement to the community and by submitting the annual statement of compliance to the HSE / funder.

Professional and Regulatory Bodies - Quality assurance information such as information received from regulators and professional bodies can be utilised to drive quality improvement. The board can frequently review the themes and nature (i.e. positive or negative) of the feedback from independent sources and comparing this to other internal sources of feedback, for example, National Clinical Audits and Specialty Quality Improvement Programmes.

Other Service Providers - Boards can learn from other similar service providers by participating in networking and conferences. Boards need to be aware of and understand where their organisation stands in relation to the best. Participating in collaborative and benchmarking initiatives enables boards to connect with wider communities in gaining this insight.

... remember that non-executive directors are the eyes and ears of the outsider but have privileged access to the inside of the hospital. That is your value to patients, to the executives and to the board. Use it well but take your time – thoughtful reflection about what can go wrong and why is all too rare, and we need lots more of it at every level of the system... Commit yourself to a year-long schedule of informal visits to wards, clinics and departments... Be patient and gradually the workings of the hospital will reveal themselves. Be persistent and word will spread that the board is seriously interested in the work of caring for patients and the conditions that make it possible.

(extract from Cornell, 2013)

Communicating a Quality and Safety Programme and Strategy to Key Partners and Stakeholders

To support consistent and effective communication, it is important for healthcare providers to take a transparent and proactive approach to the communication of their quality and safety strategy and associated programme with key stakeholders. This includes the following activities:

- Including quality and safety priorities in all board / CEO presentations or speeches
- Holding meetings with stakeholders in small groups or community hall settings
- Publishing minutes of meetings and holding public board meetings
- Displaying quality and safety messages in posters, bulletin boards and websites associated with the healthcare provider
- Proactively communicating clear, consistent messages and examples of quality and safety programmes in action in internal and external newsletters
- Building staff knowledge and skills through training and education forums or seminars, and
- Building conversations and creating connections with stakeholders through social media sharing.

Developing an integrated / multifaceted communication strategy with the executive supports the creation of a positive quality and safety culture. The communication strategy should aim to:

1. Demonstrate that the provider takes its responsibility and accountability for quality and safety seriously
2. Highlight impending changes that may impact the quality and safety culture
3. Inform the stakeholders of their role in the quality and safety initiatives
4. Demonstrate transparency and good stewardship of public funding
5. Champion and create a positive attitude around the quality and safety strategy for the organisation
6. Proactively communicate content that enables education and behaviour change, and
7. Manage communications plans and resources to delivery agreed quality and safety outcomes and value for money.



Board Considerations - Partnerships for Improving Quality and Safety

- How does our board include all relevant stakeholders in the decisions that affect them?
- What methods does our board use to hear service user and staff stories on quality improvement and safety at board meetings?
- How is quality and safety data presented in a meaningful way? (i.e. from a service user / staff perspective)
- How does our board meet directly with staff and hear their suggestions for improvement?





Methods for Improving Quality and Safety

“All quality improvement methods highlight the importance of accessing the unique knowledge that frontline staff possess and involving them in any change and improvement process. Improving the quality of care, and sustaining it, requires all programmes to have a theory of change that is based on the application of improvement science” (Health Service Executive, 2016a)

Quality Improvement Approaches

There are many approaches a provider can take when applying quality improvement methods. Chief executives of the majority of provider trusts rated 'outstanding' by the Care Quality Commission UK credit established quality improvement (QI) methods for improvement in their operational performance, staff satisfaction and quality outcomes (NILDB, 2016). The board plays a role in supporting the executive management team on the resourcing and promotion of the chosen quality improvement method. Building staff improvement knowledge and skills is an essential part of the implementation of a programme and will enable the prioritisation of key quality and safety solutions to prevent harm and improve care. Outlined below are some of the approaches healthcare providers can take when starting on a journey of quality improvement (Batalden, et al., 2007) and providers may wish to follow a number of different methods depending on what is to be achieved.

HSE Framework for Improving Quality

The HSE launched a *Framework for Improving Quality in our Health Service* (HSE, 2016a) which assists services to implement sustainable quality of care improvements in order to provide better experience and outcomes (See Figure 3). Six key critical success factors make up this framework and enable services in achieving a culture that places the person at the centre, reliably delivers safe, effective, equitable, personalised care and continuously seeks improvement. The six drivers based on international experiences in improving quality are summarised in Table 4.

Figure 3: Framework for Improving Quality in our Health Service (HSE, 2016a)



Table 4: Framework for Improving Quality Drivers	
● Leadership for Quality	Leadership that supports and fosters a culture of continual learning and improvement. Leaders shape culture, create the conditions and model the behaviour necessary for quality to flourish.
● Person and Family Engagement	Engaging and involving service users in the design, planning and delivery of all care demonstrates a commitment to person centred care. Engagement builds a culture of listening to and learning from the care experiences of service users and their families.
● Staff Engagement	An engaged workforce is one where staff are valued, listened to and provided with the tools, resources and skills to do meaningful work.
● Use of Improvement Methods	Using improvement methods highlight the importance of accessing the unique knowledge that frontline staff possess and involving them in any change and improvement process.
● Measurement for Quality	Information and measurement are central to improving quality of care. Building measurement into all improvement methods.
● Governance for Quality	Governance for quality involves having the necessary structures, processes, standards, oversight and accountability in place to ensure that safe person centred and effective services are delivered.

Methods

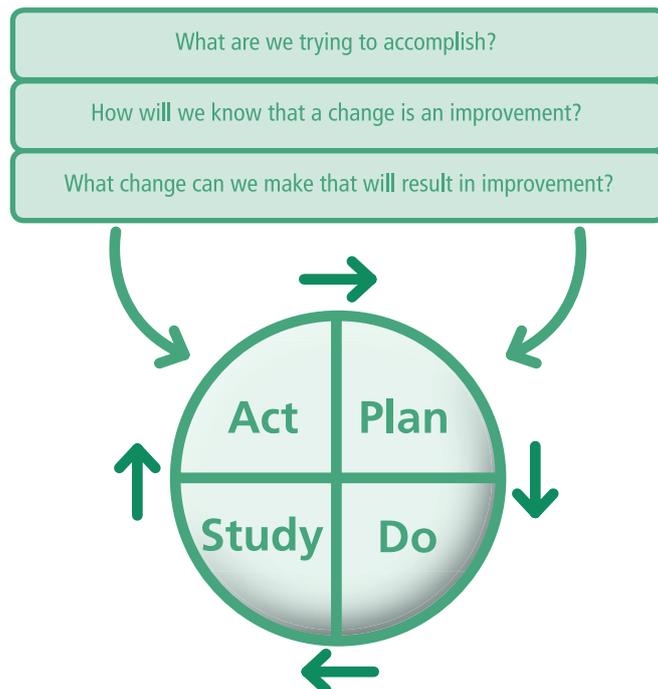
Model for Improvement- The Institute for Healthcare Improvement uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement developed by Associates in Process Improvement (Langley et al., 2009) is a tool for accelerating improvement. Testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles which are linked with three key questions (see Figure 4):

Question 1: 'What are we trying to accomplish?'

Question 2: 'How will we know that a change is an improvement?'

Question 3: 'What changes can we make that will result in improvement?'

Figure 4: Model for Improvement



Source: Adapted from Model for Improvement from Associates in Process Improvement Langley et al., (2009)

Microsystems - Is a quality improvement approach developed by Dartmouth Institute, USA. It is a pragmatic and intuitive approach which focuses on frontline teams working together using a structured approach to improve the quality of care for service users and the work environment for the staff who work there. They are the small functional frontline units that provide most healthcare to most people. Leadership is critical to enable the time and space for improvement work to happen.

For more information: www.sheffieldmca.org.uk www.clinicalmicrosystem.org. <http://hse.ie/eng/about/Who/qualityandpatientsafety/staffengagement/microsystems/>

Lean – A quality management system developed by Japanese car manufacturers focusing on value, flow and waste reduction. Lean thinking means using less to do more. The principles of Lean management can, in fact, work in healthcare in much the same way they do in other industries. The approach focuses on five principles: customer value; managing the value stream; regulating flow of production (to avoid waste and bottlenecks); reducing waste; and using 'pull' mechanisms (responding to demand) to support flow. (Source: <http://www.leanacademy.nmhs.ucd.ie/>)

Six Sigma - This is a process or product improvement approach developed by Motorola and now widely used in other industries. It focuses first on understanding how an organisation's customers would define 'defects' within its products or services and then works to reduce variation factors that customers would define as being critical to quality, using statistical methods to develop standards for variation in quality (The Health Foundation, 2013a, Boaden et al., 2008).

Total Quality Management (TQM) - Total quality management, also known as continuous quality improvement, focuses on changes in culture, processes and practice. It is an approach that is applied to the whole organisation, including factors such as leadership, customer focus, decision making and a systematic approach to management and change (The Health Foundation, 2013a).

Business Process Reengineering (BPR) - Business process reengineering (BPR) approach involves a rethinking of how processes are designed. Organisations are restructured around key processes (defined as activities or sets of activities) rather than specialist functions. (The Health Foundation, 2013a).



Board Considerations - Methods for Improving Quality and Safety

- How can our board support the organisation to select and implement proven methods for quality improvement that meets the needs of the organisation?
- How can our board support the organisation to continuously assess its competencies and capacity for improvement?
- How can our board ensure the creation of posts specifically to drive and sustain improvement's in care?





Measurement for Improving Quality and Safety

"Improvement focused oversight is better serviced by measurement processes (Statistical Process Control and Run Charts) that encourage action when the data signals concerns or success – rather than requiring effort of actions responding to inherent variation in the data being considered"

(National Health Service Scotland, 2017)

Measurement and information for quality and safety means boards having relevant and informative measures and that these measures are presented in an accessible way. The board can understand and use them to seek assurance and assess current performance objectives and inform quality and safety programmes. Organisations will have a large suite of indicators collated for regulation or performance purposes e.g. National Performance Scorecard. Indicators can measure the quality and safety of different aspects of care delivery. Measures that are relevant to the board should answer the basic questions of “is our care getting better”? (Canadian Patient Safety Institute, 2011). Boards can select a small set of agreed measures to focus on linked to improvement strategies over time.

These measures can be balanced to reflect agreed domains of quality and safety for example, the “Standards for Safer Better Healthcare” (HIQA, 2012a):

- Person Centred Care and Support
- Effective Care and Support
- Safe Care and Support
- Better Health and Wellbeing.

Quality improvement measures for boards can include data such as mortality data, infection rates, staff and service user experience. Organisation-wide measures can enable boards to benchmark their provider and to monitor progress over time. Boards can also support the organisation’s management team in sustaining a strong reporting culture within the provider they have oversight for (Tsai et al., 2015). Robust data collection and data validation processes are an integral part of an effective measurement for improvement programme. A successful measurement system includes:

- Multiple sources of information
- Selection and prioritisation of measures
- Presentation of measures
- Analysis and use of measures for understanding trends over time
- Understanding of variation and benchmarking against peers.

Different groups in the organisation will have different focal points for monitoring quality and accordingly, indicators need to be measured at different levels. A common framework is to classify indicators as ‘big dots’ or ‘little dots’ (Martin et al., 2007). The source of the information below has been adapted from *A guide to developing and accessing a quality plan* (Collaborative for Excellence in Healthcare Quality, 2012).

Big Dots are the key focal point for the board and the executive team, sometimes referred to as whole system measures (Doolan-Noble et al., 2015; Heenan et al., 2010). They are:

- Measures used to evaluate overall organisational performance and the effectiveness of strategies
- Institution-wide
- Outcome driven
- A reflection of the organisation’s strategic priorities and quality definition
- Multi-faceted connections to the “Little Dots” or processes.

Little Dots are the focal point of the executive team responsible for quality and safety and are:

- The operational measures that lead to the desired outcome or ‘Big Dots’
- Outcome Measures (specific and targeted to measure activity progress). Examples of outcome measures include: infection rates, mortality, service user experience
- Process Measures (assess what the healthcare provider did for the service user and how well it was done). Examples of process measures include: proportion of patients with myocardial infarction who received thrombolysis, nursing and midwifery quality care metrics
- Structures Indicators (measuring people, space or money) e.g. access to specific technologies or units, e.g. MRI scan and stroke units.



Multiple Sources of Information Available to the Board

Boards have many sources of information on the quality and safety of services from the organisation:

- Actions arising from incidents, serious reportable events, case reviews
- Items on the risk register
- Results from national and local clinical audit programmes (e.g. National Office of Clinical Audit and National Quality Improvement Specialty programmes)
- Assessments against standards
- Data on performance and activity – quality of care indicators measured over time
- Service user and staff suggestions for improvement.

Prioritisation of Measures

On an annual basis, a small group of key quality measures can be prioritised reflecting a board organisational improvement strategy. Measures can be prioritised using local prioritisation tools / checklists (see Resource for template) or based on analysis of a number of sources of information.

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

Source: adapted from Machell *et al.*, (2009)

Presentation of Measures

Prioritised measures can be presented in a visual board of directors' quality dashboard format. The use of Statistical Process Control (SPC) charts / run charts are particularly valuable for driving and demonstrating quality improvement and the board may wish to seek specialist advice on the best charts to use (Perla *et al.*, 2011; Schmidtke *et al.*, 2017). This approach examines the difference between natural variation (known as 'common cause variation') and variation that can be controlled ('special cause variation'). Data is collected over time to show whether a process is within control limits in order to identify areas for improvement. Run charts / SPC charts can be presented in a format that demonstrates performance over time, thereby providing an opportunity for identifying the impact of an improvement activity and whether a variation is expected or unexpected. The chart can be annotated to describe reasons for variation (see Resource for guidance on charts). The introduction of control charts into board papers is a simple process that would greatly improve board members' ability to avoid reacting to and acting on data that only shows expected variation. In so doing considering the role of chance in their decisions and ultimately provide better management for service user care.

Great Boards are able to articulate the difference between common cause and special cause variation; they can read a control chart and understand the relationship between, measurement, improvement and results.

(The Health Foundation 2013).

Understanding Measures

Performance measures that can be easily interpreted by all executive and non-executive members of a healthcare board can be a timely assessment of current performance in targeted areas (for example monthly data points). On an annual basis, guidance and support can be provided to the board on understanding new measures prioritised. Briefing on the principles of measurement for improvement and the presentation and display of data are an integral part of board induction and development programme (NHS Scotland, 2016a).

Reflections on the Mater Hospital Board on Board Project ... The board of directors' quality of clinical care dashboard 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 the top of the agenda.

(Prof Mary Day, former CEO Mater Hospital, 2014).

Analysing and Using Measures

For each board meeting, the measures are updated to reflect current performance. Trends are highlighted in a summary report to the board. Tools such as an ISBAR (Identify-Situation-Background-Assessment-Recommendation) can aide in structuring the discussion and assessment of measures and to support the presentation of actions and recommendations made by the board (see Resource for sample dashboard and ISBAR flow sheet). As part of the review of measures, integration with other data sources such as qualitative data (e.g. service user feedback / surveys / outcomes of audits) will ensure that the themes presented are consistent. The organisation's results can also be reviewed in relation to comparable organisations via national clinical audit programmes and all other nationally comparative data.



Board Considerations - Measurement for Improving Quality and Safety

- Do we know how good we are? *(depends on availability of organisational data and whether the board and executive review the data to assess performance)*
- Do we know where we stand relative to the best? *(most healthcare providers look internally at data, but have limited ways of knowing where they stand relative to other organisations, when they see that gap, it's often very provocative)*
- Do we know where our variation exists? *(even if a healthcare provider is measuring and reviewing data—both internally and as a benchmark against comparable providers—what good is the data if it doesn't identify weakness)*
- Do we know our rate of improvement over time? *(most people think that they're getting better much more quickly than they actually are, walking through these four questions is often a provocative assessment and does help providers speed up the velocity of improvement in their organisation)*

Source: Adapted: from Bisognano (2013)





Risk Management and Assuranced Assurance

"Quality and risk management are complementary and together, are key components of healthcare governance. Effective risk management underpins healthcare quality management activity"

Risk Management is about being aware of the potential of things that can adversely affect your service (risks) and putting in place actions (controls) to make sure that the likelihood of them occurring is reduced in so far as is reasonably practicable. Health services are inherently risky: their core activities involve a response to unpredictable events where the potential for harm is high. Healthcare providers' sensitivity to operations, together with anticipation and preparedness enables them to reliably manage risks in the interests of both service users and staff (Vincent et al., 2013). The HSE launched an updated *Integrated Risk Management Policy* in March 2017c, outlining the policy of the HSE to manage risk on an integrated basis. All services manage risk by proactively identifying risks that threaten the achievement of objectives, e.g. the delivery of high quality safe care, compliance with legal and regulatory requirements and to putting in place actions to reduce these to an acceptable level. Risks can be identified as either strategic or operational.

Assurance processes are sometimes considered to be at odds with quality improvement. In practice processes such as risk management, compliance reporting, scrutiny and inspection are integral to improvement and provide learning and pointers to opportunities for improvement.

When people say, 'quality and safety', what I hear is 'fruit and bananas'. Quality improvement is the big tent. It's the enterprise of constant improvement to everything we care about. The quality of my car is dimensional. It has safety, durability and fuel economy and so does healthcare. I think reuniting our endeavours is crucial to our future. We don't have the resources to waste on tribalism. We have to think systematically.

(Berwick, 2017)

Board Assurance

Boards of healthcare providers oversee proactive risk management by ensuring the following is in place:

- **Quality and Safety Plan:** A comprehensive quality and safety plan is in place which includes risk management.
- **Board Committee:** A board quality and safety committee is in place with terms of reference (that includes risk) which meets regularly and provides assurance to the board.
- **Risk Register:** The board reviews and monitors the services risk register, ensuring appropriate action is taken to mitigate risks.
- **Standards / reviews:** The board has a mechanism in place to monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. HIQA, HSE Audit, Health and Safety Authority and ensure there is a plan in place to address compliance.
- **Audit Plan:** The board informs and monitors the annual audit plan.
- **Report Analysis:** The Board critically analyses reports received from the Executive Management Team in respect of risk management, serious reportable events and incident management.
- **Strategy:** The board has assessed its strategic objectives and identified the following:
 - Risks to delivering strategic objectives and controls in place to support delivery
 - Sources of assurance and deficits in control
 - Obtaining assurance on action plans for mitigating risks to board strategy



Risk and Incident Management

Effective governance for quality and safety structures ensure that there are clear lines of accountability for risk and incident management and that all staff are aware of their responsibilities and accountability. The management of incidents is an executive responsibility, the board has a key role in providing support and oversight. The board seeks assurance that the structures and processes for incident management are working effectively; thereby caring for the needs of those harmed, obtaining understanding of what went wrong and ensuring that lessons learned are implemented and shared (see Table 6). The *HSE Incident Management Framework* (2017) provides comprehensive guidance and resources.

Table 6: Principles for Incident Management	
Person Centred	The needs of persons affected (service users and staff) are considered of primary importance and required supports are put in place from the outset and throughout any review process required.
Fair and Just	That all staff are treated in a manner which is respectful and supports them to recognise, report and learn from incidents. Where issues of individual accountability are identified that the service responds to these in a manner which is proportionate and safety focused.
Openness and Transparency	That all persons affected by an incident are aware of the incident and the steps to be taken to learn from it.
Responsive	That the actions taken following the identification of an incident are taken in a timely and proportionate manner.
Improvement Focused	That incidents occurring are viewed by the service as an opportunity to improve.
Learning	That the incident management system is focused on learning both locally and within the wider service.
Source: adapted from HSE (2017d)	

Boards have a key role in creating a climate of “psychological safety” which is founded on respectful interactions by everyone and disrespectful behaviour is rapidly and consistently addressed. People feel confident that others will respond positively when they ask a question, seek feedback, admit a mistake, or propose an idea (Institute for Healthcare Improvement, 2017). Board actions, consistent with a just culture focus on staff knowing that they will not be punished for human errors in unsafe systems.

Another element of risk management relates to reputational risk. It is vital for healthcare boards to maintain the trust of the communities they serve. Concerns arising from a serious incident or poor professional standards can result in a breakdown in public confidence and can be demoralising for staff. Very often, it is how the incident is handled by the organisation and its leaders, including the board that maintains the public’s trust. In order to manage and maintain public confidence at a time of crisis it is important for boards to have a communication plan in place for when the need arises (Totten et al.,2011).



Board Considerations - Risk Management and Assurance

- Does our board take time to discuss and anticipate the healthcare provider's risks to service delivery?
- Has our board identified ways of seeking assurance on the quality and safety of services provided?
- Has our board considered the risks to delivering the healthcare providers plan for improving quality?
- Does our board have a communication plan in place for responding to a serious incident with public attention?
- Does our board have a clearly defined role in supporting the executive in responding effectively to a serious incident?





7

Planning for
Improving
Quality and
Safety

Planning for Improving Quality and Safety

"Board effectiveness relies on the ways in which board members translate this knowledge and information into quality and safety plans with measurable goals, maintain oversight on progress toward these goals, and hold the CEO and the organisation, responsible for these goals"

(Canadian Patient Safety Institute, 2011)

Setting Strategic Priorities

Leading boards embed human factors thinking in their strategic approach to improving service user safety (Clinical Human Factors Group, 2013). Great boards recognise the value in articulating an organisational improvement strategy which sets out the aim, values and goals for the future (The Health Foundation, 2013b). It can be aligned to the overall strategic priorities of the provider and the key measures selected for board review throughout the year.

The plan for improving quality has to have specific measures, timelines and targets so that board members can quickly assess progress of the provider on quality and safety initiatives. The plan can cascade throughout the organisation by having measures and targets that align with the strategic plan of the provider. Including the plan into the broader strategic plan will ensure that it is an integral part of a broader organisational strategic plan (Canadian Patient Safety Institute, 2011).

Overview of Considerations for Developing a Plan for Improving Quality and Safety

Developing a plan and improving it over time is a critically important and challenging task for any healthcare provider. It should be clearly aligned to the organisation's strategic plan; based on addressing the priorities for improvement identified from data analysis, adverse events, staff and patient feedback and suggestions; tied to a quality and safety framework and have a natural progression from previous years. The plan should be clear, easy to understand and interpret; have measurable goals and include targets; be based on resources available; evaluated on an annual basis; and be helpful in influencing permanent cultural change. The following headings are important for consideration when developing a plan for improving quality. The source of the information below has been adapted from *A guide to developing and accessing a quality plan* (Collaborative for Excellence in Healthcare Quality, 2012).

- **Accountabilities:** The development, approval and implementation of the quality and safety plan involves various groups in the organisation including: the board, the executive team, clinical leadership, and staff. Each group needs to clearly understand its roles and responsibilities.
- **Collaboration:** It is important to actively engage with services users and staff and take into consideration the views of stakeholders when developing a quality and safety plan. Gaining acceptance of the plan requires that the process for developing it is collaborative inclusive with participation of service users and staff. The following are some activities that can be performed to obtain participation in the development of the quality plan:
 - Partner with staff to proactively seek their suggestions for improvement.
 - Survey of the executive team, clinical leaders and staff to obtain input on the strategic goals.
 - Perform key stakeholder interviews to obtain perspectives on critical and emerging quality and safety challenges.
 - Analyse the data to identify themes and to prioritise goals based on the quality framework.
- **Long Term Planning:** Most providers prepare a plan for improving quality and safety which has a one-year life span. Quality initiatives often require resources and an organisational culture change that cannot be reasonably achieved in a single year. For this and other reasons, it is important that plans take a longer term perspective with respect to quality improvement targets.
- **Alignment:** The plan needs to be aligned with a variety of internal and external documents which will impact the plan such as the organisation's strategic plan, national standards and government legislation and initiatives.
- **Timeframe and Resources:** The steps involved in developing the plan are not sequential. Factors such as timeframes and resources must be considered as performance targets are established. The process may also be iterative as draft objectives and targets are examined in the light of available resources.
- **Assigning Responsibilities:** The final component of the plan is the identification of individuals or groups that have specific accountabilities for achieving the desired results. Accountabilities may exist at various levels of an organisation.



Communication of the Quality and Safety Plan

Once the plan is finalised and approved by the board of directors, it can be communicated to a variety of internal and external stakeholders. The plan aims to inspire, motivate and attain sustained cultural change, so it is important that it has visibility with staff, service users and management at all levels. Communication of the plan can include external groups, for example, service users, families, funders, suppliers, the media and affiliated organisations.

Communication of the plan serves to:

- Engage and bring awareness of the plan and set the expectation of change
- Highlight upcoming initiatives and possible opportunities for involvement
- Demonstrate board and executive team support for quality and safety as a priority
- Be transparent about goals, targets and metrics
- Garner understanding and alleviate any insecurities about how the plan will impact staff or the achievability of targets
- Motivate a positive attitude and receptiveness to participating in the journey the provider is undertaking.

Reporting: The purpose of a plan is to bring about change and improvement in quality and safety in an organisation in a measurable way. For this to be effective, it is important that a process for reporting on the performance of the plan be put in place.

Assessing the effectiveness: It is important to spend time each year assessing the effectiveness of the plan in achieving its desired aims. The board can play a role in leading this assessment. A report should be presented which outlines the accomplishments and shortcomings of the plan along with factors that influenced the performance of the plan. The quality committee of the board can play an important role by leading this assessment.

The plan approved by the board and implemented by the executive will further support the board's relationship with the provider as a whole by:

- Promoting a quality and safety culture
- Clearly demonstrating board commitment to quality and safety priorities
- Understanding and use of a common language for quality and safety
- Aligning board activities with the providers' services.



Board Considerations - Plan for Improving Quality and Safety

- Does our board set quality and safety priorities and targets with the executive?
- Our board priorities are reflected in the overall strategic plan for our services?
- Has our board identified ways of knowing that the provider has met these aims?
- Has our board a way of knowing the plan is communicated to both internal and external stakeholders?
- Does our board have mechanisms to review, monitor, evaluate and celebrate progress against the plan?

Reflections from Board Members



Reflections of a Board Chair – A Canadian Perspective

Selecting people with the right “stuff” is very important. While you can grow your own experts in the area of quality and patient safety, it helps if you are very clear identifying the types of skills and experience required when recruiting and appointing board members. I would strongly recommend recruiting at least a couple of people onto boards, where possible, who have manufacturing or transportation backgrounds with proven continuous improvement orientation. Also, adding people with strong customer service backgrounds, not just in delivery but in fundamentally understanding how to imbed a service ethos into staff.

The successful “on boarding” of new members via a structured induction and orientation program to acclimatise new board members to the work of the board is a vital component of successful board participation. If you have the right people at the table, the learning curve can be sped up through a robust orientation programme supported by ongoing active coaching and mentoring from the experienced folks around the board table who are willing to invest time in new members during their first year. It should be clearly stated during the recruitment phase for new board members, that much of the journey may involve self-directed learning.

There has been a real shift in emphasis (over the last decade or so) from processes to outcomes. It is a board’s responsibility to ensure the right “processes” are in place, however the real value a board brings or a highly functioning quality committee adds, is on understanding outcomes and variation in care and or improvement over time. Patient stories are very helpful but are most helpful if tied to an indicator or initiative that is in front of the board.

A board’s response to critical incidents is also important, If the learning from an incident is of benefit to others it can be shared broadly throughout the organisation and beyond. The review of specific critical incidents within healthcare, while very sobering, can serve to galvanise board focus. Whilst it is not a board’s role to investigate, it is a board’s role to ensure that investigations are effective, processes are reviewed and changed where indicated and lessons learned are widely communicated. A board’s response to these incidents also contributes to establishing a quality and safety culture within the organisation. To this end, a board needs to understand Human Error / Factors and the importance of ensuring accountability within the organisation through a “Just Culture”. Within a Just Culture, incidents are investigated to find and understand root causes – often system or process related, rather than focusing on assessing blame or individual culpability.

“As a board member, we are not simply passive receivers of information and gone are the days of simply showing up”

Ruthe Anne Conyngham, Past Chair of the Canadian Healthcare Association and the Ontario Hospital Association.

Reflections of a Board Chair – An Irish perspective

The Mater Hospital is focusing on becoming the safest and most efficient hospital in Ireland, and that goal is dependent on creating cultures where leadership, openness, reporting and sharing the learning are at the core of operations from bed to board. Our Board completed a *Board on Board with Quality of Care* Project in 2015 and 2016. This has strengthened our governance for quality and safety by providing the board of directors with a real picture of the quality of clinical care and rebalanced the board agenda in favour of quality of care. I am pleased to share my reflections on our journey in achieving that shift in focus:



Board Assurance: Assurance at board level as to the quality of care delivered is through reviewing a small number of prioritised 'outcome measures' or as some refer 'the big dot' measures. These 'big dot' measures are system measures, the outcomes of a series of interconnecting processes in delivering patient care. If the outcome measures are below target or demonstrate a trend, the board uses the information to question the executive management team; and make assessments and recommendations regarding hospital business. This provides strong accountability between board and the executive.

Quality Data: The board now get a balanced view of information and a more comprehensive picture of (i) finance, (ii) access and (iii) quality of clinical care delivered to patients. The information is presented via a *board of directors' quality dashboard*. All of the information is represented on one page, grouped by quality domains and aligned to the *National Standards for Safer Better Healthcare* (HIQA, 2012) and the board quality and safety priorities. The dashboard and accompanying report are circulated prior to the board meeting and provide us with context to the information and enables us to be prepared for a focused discussion at the board meeting.

Board Education: Our board took dedicated time-out to review quality of clinical care in a focused and strategic way through a tailored workshop / targeted reading and this provided the time and space to learn about quality of clinical care, how to prioritise information and understand measures.

Prioritisation of Board Agenda: Our board meeting agenda has been rebalanced in favour of quality. The quality of clinical care provided to patients has a priority position and gets at least 40% of time of the board meeting. This has facilitated a thorough discussion and recommendations surrounding the quality of clinical care.

Patients Voice: We have also introduced patient stories into all board meetings. This has strengthened the voice of patients and has led to the 'humanising' of the dashboard numbers that we review at meetings. Through this process the board get a greater insight of patient experience (good and bad) and the patient context when considering what the dashboard trends are telling us.

Integration of Finance and Quality: We have come to appreciate that quality and financial data should always be integrated: they are always two sides of the same coin. However, getting the right data is essential. Without the right data a board is flying blind. The board monthly dashboard allows us to navigate effectively and provides clarity on the direction of travel.

Board Decision Making: We can now see how the shift in focus towards informed decision making based on; quality of care measures, informed by patient stories, and context provided by executives has positively influenced patient care. This has also influenced the overall culture of patient safety.

"The boards work regarding quality of care is the start of a journey and we are continuing this journey"

Tom Lynch, Chair, Board of Directors Mater Misericordiae University Hospital

Reflections of a Non-Executive Board Member

Temple Street Children's University Hospital, is an acute national paediatric hospital providing care for 145,000 children each year. A voluntary Board of Directors of four executive and nine non-executive members are accountable for the services provided.



Reason for Joining: I joined the Children's University Hospital Temple Street board as a Non-Executive Director (NED) in October 2015, as contributing to the community and country is something I feel strongly about. Having retired from the public healthcare system and completed a board programme in the Institute of Directors in Ireland, my experience matched the competencies of a NED for this hospital and my nomination was approved by the board.

Preparing for the NED Role: The board programme at the Institute provided me with a real understanding of the responsibilities of a NED role and helped me to differentiate between being a board member and a member of the executive. One of the board members acted as a mentor to me which was very beneficial and the board were very welcoming. I went through an induction process and was provided with helpful information e.g. previous annual reports, board papers, articles of association etc.

Board Responsibility: Everyone on the board is accountable and has to take collective responsibility for the decisions of the board. I knew that clinical quality and safety was my area of expertise but I also needed to understand the other issues the board would be discussing. The board culture is very supportive and encourages open questioning, clarifications and challenge of all matters discussed which assisted me in learning the non-clinical aspects of board business.

Preparation for board meeting: Reading the documentation in advance of board meetings is critical. Knowing that I am legally accountable I need to fully understand what I am signing off on and the implications of decisions made at the board table. I would be very uncomfortable coming to a meeting if I hadn't read the documents and followed up on matters in advance if needed. The executive team and staff work hard preparing reports for and are dependent on the decisions of the board and therefore need the full attention of the directors for each of the monthly meetings.

Quality and Safety Committee: I am chair of the board quality and safety committee, it's a new committee being set up in a new structure and operates within the HSE guidance for Quality and Safety Committees. A key responsibility of the committee is judging what is the right information for the committee Vs what is the right information to present to the full board. The board committee has relevant executive expertise and two parent representatives whose contributions are greatly valued.

Board members development: I am a member of the Institute of Directors and I attend meetings regularly (every four to six weeks). They host guest speakers who provide updates on many topics e.g. national and EU legislative changes and I find them invaluable. The hospital has been collaborating with the Health Service Executive in a *Board on Board* learning project. This is helping board members develop their knowledge and understanding of quality of care; what the board needs to know and what questions the board needs to ask to ensure that the quality of care is improving. NEDs who have not come from a clinical background need a specific education / training programme as healthcare is so complex.

Top tips for future board members

1. If you are invited to join a board, ask lots of questions, review their annual report, ask to speak to other board members, learn how they do their business.
2. Find some group where you can gain ongoing education and development for your board role. Learn how you can access board best practice which will make it much easier to contribute.
3. Prepare well for board meetings by reading all material in advance of the board meeting.
4. Connecting with staff is really important e.g. walk-rounds, observing safety huddles, attending functions. There is nothing like being out there meeting directly with staff.
5. Look for evidence of quality and safety and recognise this. Congratulate staff and recognise their excellence when the opportunity arises.

"If you get an opportunity to join a voluntary board, take it. Utilising my experience and expertise in this way has been an enriching and developmental experience".

Aveen Murray, Non-Executive Board Member, Temple Street Children's University Hospital and Chair of Board of Directors Quality and Safety Committee.

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Glossary

Term	Description
Accountability	Obligation of an individual or organisation to account for its activities, accept responsibility for them, and to disclose the results in a transparent manner.
Adverse Event	Adverse events are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical centre, outpatient clinic, or other facility. Adverse events may result from acts of commission or omission.
Big Dots	These are system level measures and equate to outcomes of core processes or functions of the organisations in the system. They are not programme, unit or disease specific.
Care Pathway	An agreed and explicit route an individual takes through health and social care services. Agreements between the various providers involved will typically cover the type of care and treatment, which professional will be involved and their level of skills, and where treatment or care will take place.
Chief Executive Officer	For non-profit organisations, is the highest-ranking corporate officer (executive) or administrator in charge of total management of an organisation. The individual appointed as a CEO of a corporation, company, organisation, or agency typically reports to the board of directors.
Clinical Audit	Clinical Audit is a clinically lead quality improvement process that seeks to improve care and outcomes through systematic review of care against explicit criteria and acting to improve care when standards are not met. The process involves the selection of aspects of the structure, processes and outcomes of care which are then systematically evaluated against explicit criteria. If required improvements should be implemented at an individual, team or organisation level and then the care re-evaluated to confirm improvements.
Clinical Director	A medical doctor who has a leadership role for one or more specialties within a hospital. The primary role of a Clinical Director is to manage and plan how services are delivered and contribute to the process of strategic planning, influencing and responding to organisational priorities. This involves responsibility for agreeing an annual Directorate Service Plan, identifying service development priorities and working with the CEO to align directorate service plans with hospital or group plans. Clinical Directors report to - in a voluntary hospital or agency: The Chief Executive; - under the Health Service Executive: Hospital Manager. It is proposed that the Clinical Director be accountable for resources used, directly and indirectly, by the Directorate and the transformation of these resource inputs into pre-planned and commensurate levels of service output in line with clinical need and as defined in patient service or other relevant terms and agreed with the employer.
Community Healthcare Organisation	Community Healthcare Services are the broad range of services that are provided outside of the acute hospital system and include Primary Care, Social Care, Mental Health and Health and Wellbeing Services. These services are delivered through the HSE and its funded agencies to people in local communities, as close as possible to people's homes.
Corporate Governance	The system by which companies are directed and controlled. An important theme of corporate governance is the nature and extent of accountability of people in the business.
Culture	A lens through which an organisation can be understood or interpreted both by the members who make up the organisation and by interested external parties through an appreciation of an organisations symbolic codes of behaviour, rituals, myths, stories, beliefs, shared ideology and unspoken assumptions.
Dashboard	Unlike a scorecard which is a snapshot in time, a dashboard uses trend data (real time) to assist decision making.

Term	Description
Executive Director	A member of the board of directors of a company who is also an employee (usually full-time) of that company and who often has a specified area of responsibility, such as finance or production.
Governance for Quality	Governance for quality involves having the necessary structures, processes, standards, oversight and accountability in place to ensure that safe, person centred and effective services are delivered.
Hospital Group	The hospitals in Ireland are organised into seven Hospital Groups. The services delivered include inpatient scheduled care, unscheduled / emergency care, maternity services, outpatient and diagnostic services. The Group Chief Executive of each Hospital Group reports to the National Director for Acute Services and is accountable for their Hospital Groups planning and performance under the HSE Accountability Framework (2015).
HSE Directorate	The Directorate is the governing authority of the HSE established following the enactment of the Health Service Executive (Governance) Act 2013.
Human Factors	All the people issues – how we see, hear, think and function physically – as well as the interrelationship of people and their environment and to each other which need to be considered to optimise performance and assure safety.
Little Dots	These are processes indicators at a programme or unit level.
Identify-Situation-Background-Assessment-Recommendation (ISBAR)	A communication tool used in a simple way to plan and structure communication (verbal and written).
Incident	An event or circumstance which could have, or did lead to unintended and / or unnecessary harm. Incidents include adverse events which result in harm; near-misses which could have resulted in harm, but did not cause harm, either by chance or timely intervention; and staff or service user complaints which are associated with harm. Incidents can be clinical or non-clinical.
Non-executive Director	A director of a commercial company who is not a full-time member of the company but is brought in to advise the other directors. The role of the non-executive director is to balance that of the executive director, so as to ensure that the board; as a whole, functions effectively. Non-executive directors can make a significant contribution to the development, governance and success of a company. There are no legal distinctions in the responsibilities of executive and non-executive directors under Irish company law.
Open Culture	A culture of trust, openness, respect and caring where achievements are recognised. Open discussion of error is embedded in everyday practice and communicated openly to patients. Staff willingly report adverse events, so there can be a focus on learning, research and improvement, and appropriate action is taken where there have been failings in the delivery of care.
Open Disclosure	An open, consistent approach to communicating with service users when things go wrong in health care. This includes expressing regret for what has happened, keeping the service user informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event.
Patient Advisor	A patient and family advisor is someone who: Gives feedback based on his or her own experiences as a patient or family member.
Person Centeredness Person Centred Care	Person Centred Care - An approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.' A focus on respect; choice; empowerment; involvement of patients, carers and staff in health policy; access and support; information.

Term	Description
Policy	<p>A policy is a written statement that clearly indicates the position and values of the organisation on a given subject.</p> <p>A Clinical Policy can be defined as a written operational statement of intent which helps staff to make appropriate decisions and take actions, consistent with the aims of the service provider and in the best interests of service users.</p>
Quality of Care	Care that is person centred, effective, safe and results in better health and wellbeing.
Quality Improvement	The combined and unceasing efforts of everyone – healthcare professionals, service users, their families, researchers, commissioners, providers and educators – to make changes that will lead to: better service user outcomes, better experience of care, continued development and supporting of staff in delivering quality care.
Psychological Safety	Means people feeling secure and capable of changing; they are free to focus on collective goals and problem prevention rather than on self-protection; and they believe that no one will be humiliated or punished for speaking up. They know that staff will not be punished for human errors in unsafe systems, consistent with a just culture. Psychological safety is a team characteristic rather than an attribute of individuals. It is a climate in which people feel free to express relevant thoughts and feelings or speak up about unsafe conditions without retribution.
Risk	Risk is the effect of uncertainty on objectives. It is measured in terms of consequences and likelihood. In the context of the HSE and its services, it is any condition or circumstance which may impact on the achievement of objectives and / or have a significant impact on the day-to-day operations. This includes failing to maximise any opportunity that would help the HSE or service meet its objectives.
Service User	"Service user" includes "patient," "resident," "client" and "consumer". Some terms may not be appropriate or preferred when referring to individuals who access healthcare services depending on the care setting or sector. These terms are often used interchangeably in healthcare. For clarity and consistency, the term "service user" - intended to be inclusive of all terms is used throughout this guidance.
Senior Accountable Officer	In the context of the management of an incident, the senior accountable officer is the person who has ultimate accountability and responsibility for the services within the area where the incident occurred.
SRE (Serious Reportable Event)	Incidents that require reporting and subsequent investigation can be defined as events occurring in HSE funded healthcare (including in the community) which could have or did result in unintended and / or unnecessary serious harm. These are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
Standard	A "standard" helps to create a common understanding of the standard of care service users can expect to receive. A national standard provides a strategic approach and a clear benchmark with the aim of improving safety, quality and reliability within the health services.
Statutory Board	A board which completes its functions under a specific piece of legislation and who are legally responsible for the governance and oversight of an organisation.

Appendix 1: Policy Context

There are a number of relevant documents which are applicable to boards and executives within healthcare in Ireland. Examples of these documents may include but are not limited to the following:

1. Health Acts (2004, 2010, 2013)

The provisions contained within the Health Act 2004 forms the legal basis for the creation of Health Service Executive and sets out its legal requirements in relation to its code of governance. Following the enactment of the Health Service Executive (Governance) Act on 25 July 2013, the HSE Directorate was established as the governing body of the HSE.

2. Code of Practice for the Governance of State Boards

The Code of Practice for the Governance of State Bodies (2016) is designed to ensure that both commercial and non-commercial State bodies meet the highest standards of corporate governance. It provides a framework for the application of best practice and is intended to take account of developments in respect of oversight, reporting requirements and the appointment of board members. The Code is based on the underlying principles of good governance: accountability, transparency, probity and a focus on the sustainable success of the organisation over the longer term. Available at http://www.stateboards.ie/stateboards/code_of_practice.htm.

3. HSE Code of Governance

The Health Act, 2004 sets out the legal requirements for the HSE regarding its Code of Governance. It sets out the guiding principles by which the HSE is governed. Standards of governance should be underpinned by a set of key principles which promote transparency, efficiency and effectiveness. Specifically, standards should provide that a publicly-funded health sector organisation:

- acts legitimately in compliance with legal requirements, within the authority conferred;
- observes due process in all its activities and respects the rights and aspirations of other stakeholders and the public;
- meets publicly-declared standards of performance particularly relating to quality, equity, Value for Money in the use of public resources, delivery of agreed outputs and achievements of targeted health and social gain outcomes; and
- Accounts to stakeholders and to the public for its actions relating to the principles set out in the National Health Strategy i.e. quality, accountability, equity and people centeredness.

<http://www.hse.ie/eng/services/Publications/corporate/governance.html>

4. HSE Service Level Agreements (Section 38 and Section 39 HSE funded organisations)

These agreements contain part 1 and part 2 (comprised of 10 schedules) of the legal contract for agencies in receipt of funding above €250,000 funded under Section 38 / Section 39 of the Health Act. Schedule 2 describes the services structures process and oversight for quality and safety.

http://www.hse.ie/eng/about/Non_Statutory_Sector/

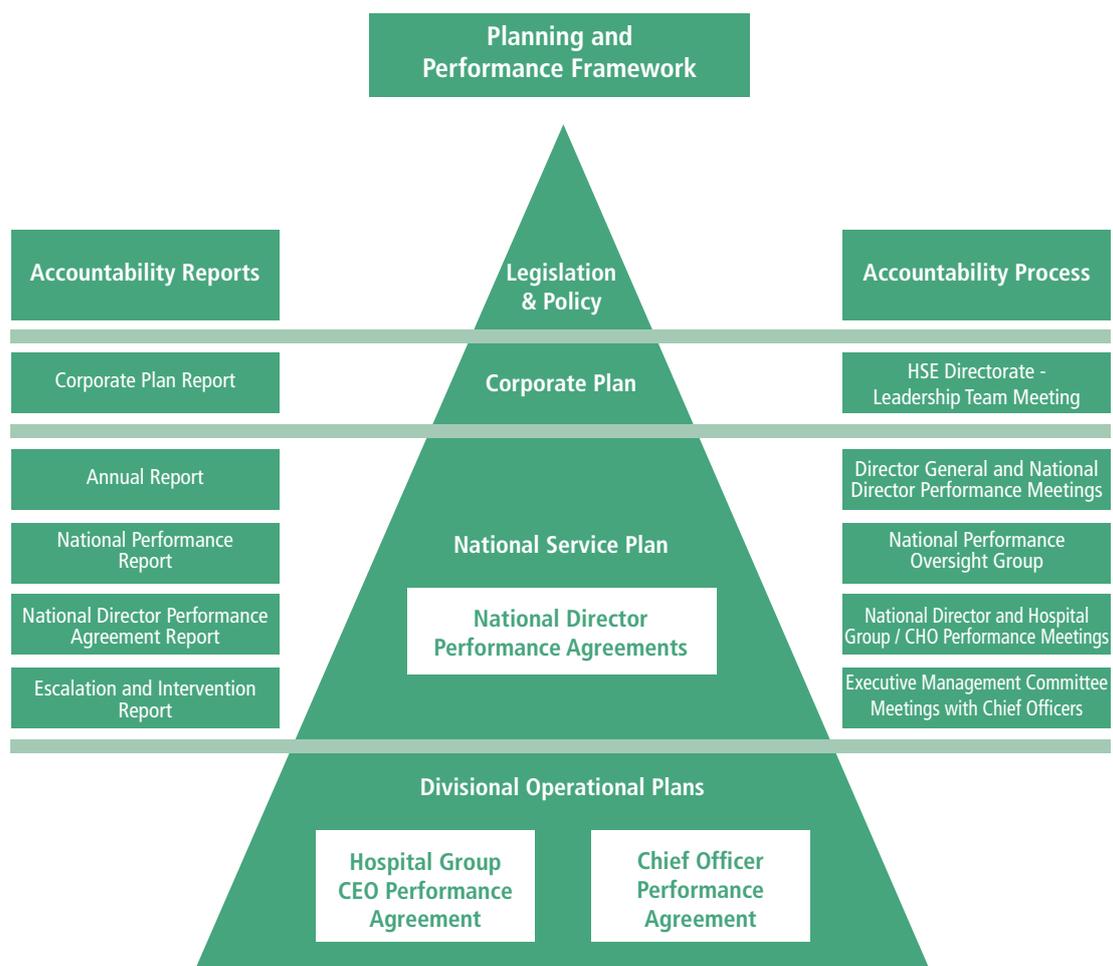
5. HSE Accountability Framework

The HSE's Performance Accountability Framework, introduced in 2015 and enhanced in 2016, sets out the means by which the HSE and in particular the National Divisions, Hospital Groups, Community Healthcare Organisations, and National Ambulance Service are held to account for their performance. <http://www.hse.ie/eng/services/Publications/corporate/governance.html>.

6. HSE Annual Compliance Statement

The Compliance Statement is an annual statement addressed to the HSE, made by Section 38 Agency board members – the chairperson and one other board member – on behalf of their board, testifying as to the agency's compliance with standards identified by the HSE in eight areas. Those areas are governance, internal controls, risk management, remuneration, finance, preservation of capital assets, taxation and procurement. The annual compliance statement for senior management within the HSE statutory services is the annual controls assurance process. http://www.hse.ie/eng/about/Non_Statutory_Sector/

Appendix 2: HSE Performance Accountability Framework



Source: HSE Accountability Framework in HSE *Code of Governance* (2015a)

List of HSE Resources

All of the resources below are available at www.hse.ie. To view additional resources and recommended reading for this publication, please visit the Governance for Quality section of the webpage www.qualityimprovement.ie

- Quality and Safety Walk-rounds: step by step guide
- Sample Board of Directors Agenda
- Sample Board of Directors Minutes
- Sample Board of Directors Quality of Clinical Care Dashboard and ISBAR prompt sheet
- Prioritising measures of quality of care checklist
- Guidance note on statistical process control charts (SPC)
- Board Quality and Safety Committee Guidance
- Quality and safety clinical governance development: assurance check for health service providers
- HSE Integrated Risk Management Policy and Templates
- HSE Incident Management, Policy, Procedure, Guidelines and Supporting Tools

About the Quality Improvement Division

Who we are

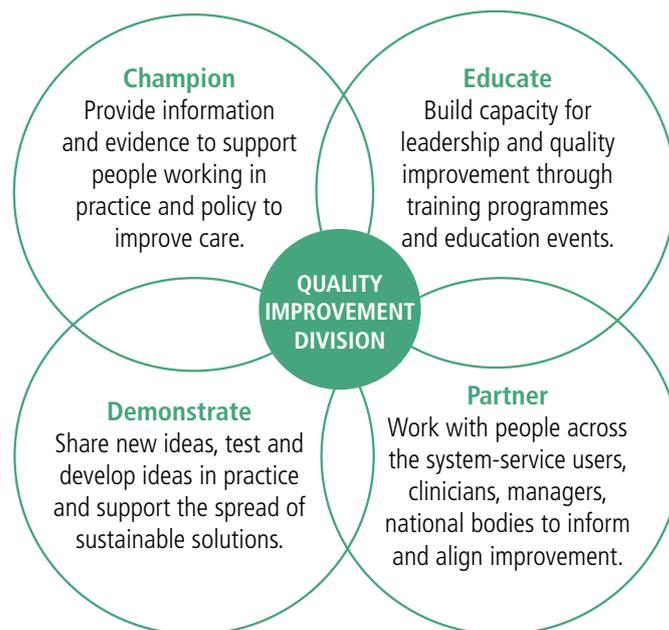
The Quality Improvement Division was established in 2015 to support the development of a culture that ensures improvement of quality of care is at the heart of all services that the HSE delivers.

Our mission

To work in partnership with patients, families and all who work in the health system to innovate and improve the quality and safety of our care.

Role and function

Our role is to champion, educate, build capacity for quality improvement and demonstrate new ideas and approaches to quality improvement.



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 Further information please see www.qualityimprovement.ie



We are all responsible ... and together we
are creating a safer healthcare system