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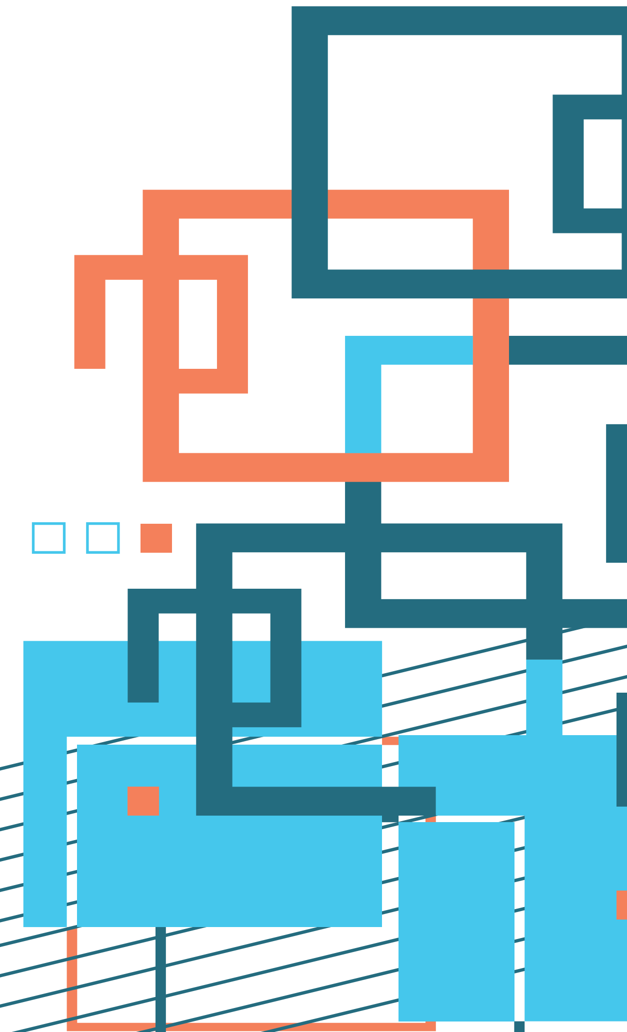
What every board member needs to know about improvement and quality assurance

A report from the Good Governance Institute and Perfect Ward

September 2021



Document name: What every board member needs to know about improvement and quality assurance

Date published: September 2021

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ISBN: 978-1-907610-70-7

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Executive Summary

What every board member needs to know about improvement and quality assurance is a report intended to guide and support boards in developing and maintaining robust quality assurance and improvement processes within their organisations.

It contains a maturity matrix, a practical tool to support boards in assessing levels of maturity within their organisations against key identified criteria and identifying the steps they need to take to progress the maturity of their organisations. The report also provides best practice examples and key questions to help boards translate theory into practice.

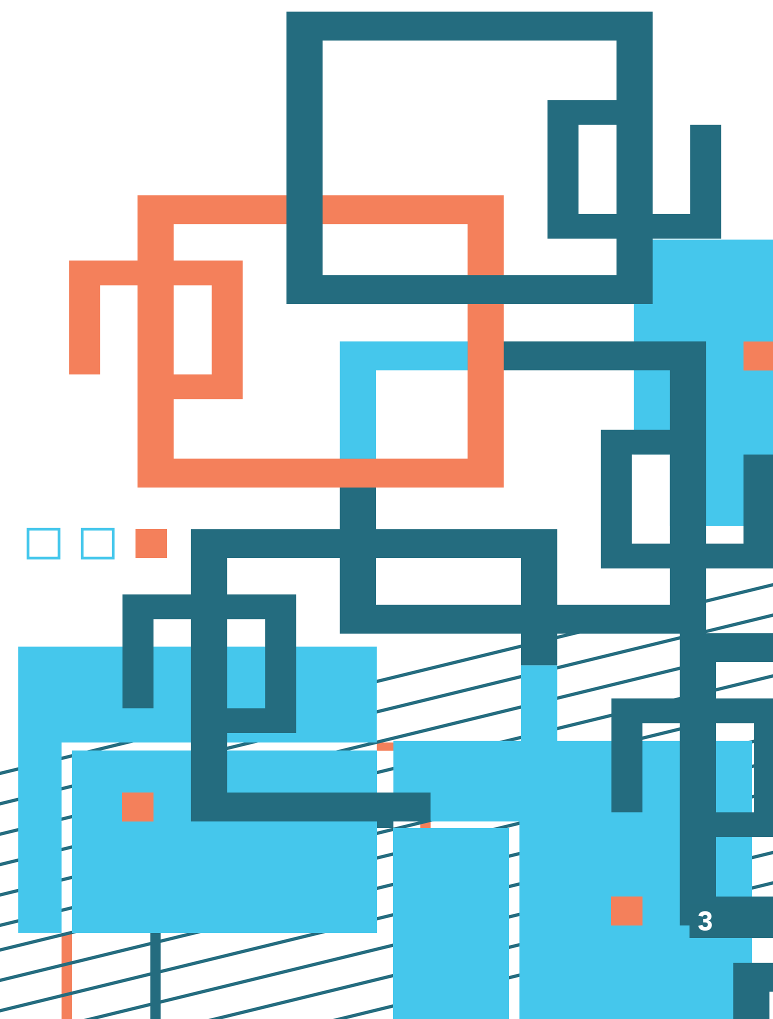
The report covers key definitions, governance principles, roles and responsibilities (including the role of regulators and other stakeholders) in relation to quality assurance and quality improvement.

Healthcare services around the world are increasingly adopting integrated approaches to the delivery of care.

The report reflects on this important development and examines how changes to the healthcare environment will impact future arrangements.

Finally, it explores the acknowledged enablers and barriers to effective quality assurance. The aim is to demonstrate the breadth of factors that can impact quality assurance, and support board members in identifying which barriers they need to tackle and which enablers they need to promote.

For further information or support in using the report and associated maturity matrix, please contact GGI at contact@good-governance.org.uk or Perfect Ward at info@perfectward.com.



Good Governance Institute

GGI exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat – in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

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Perfect Ward

At Perfect Ward, we apply the best digital technology to solve one of healthcare's most important challenges – how to continuously improve quality.

Our aim is to bring the mobile user experience we all know and love on our own phones, to the healthcare industry; a sector long underserved by technology, and reliant on manual, paper-based processes.

We created our app to empower all health and care professionals to do their quality inspections more quickly and with greater accuracy via easy-to-use technology. By using Perfect Ward quality inspections are completed up to 60% quicker, freeing up time to care and providing instant access to critical quality data for our customers.

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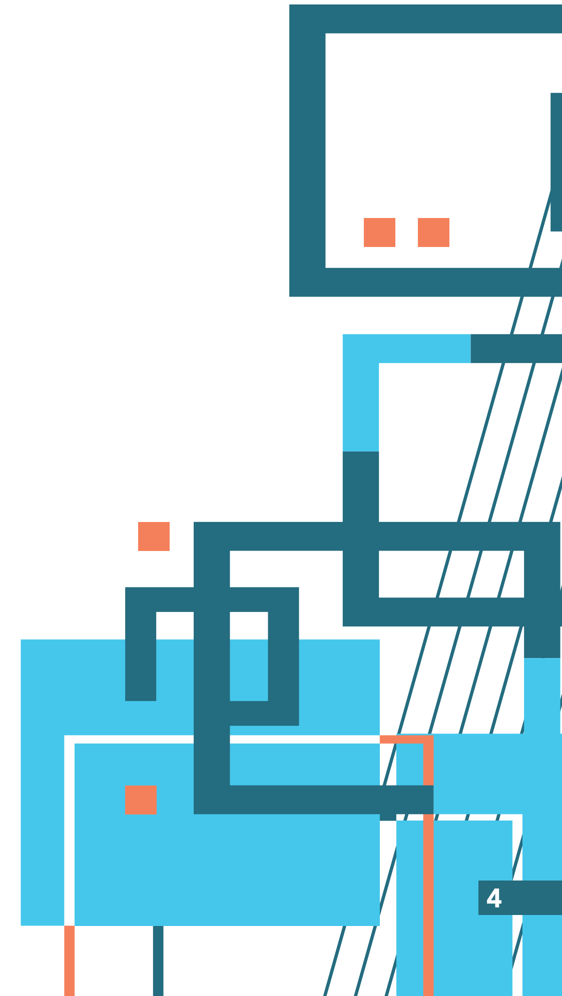


1. Introduction

The NHS arguably has one overarching purpose: to provide comprehensive, high quality and universal health care services to the people of the UK[1].

Boards are fundamental to achieving this purpose. It is they who set the strategic direction of the institutions and systems they lead, and who will need to find realistic and practical solutions to the many challenges that health and social care providers face, both in the short and longer term.

Within this, the value of good governance should not be underestimated. Indeed, we know all too well from high-profile incidents that when governance fails it can quickly lead to patient safety issues.

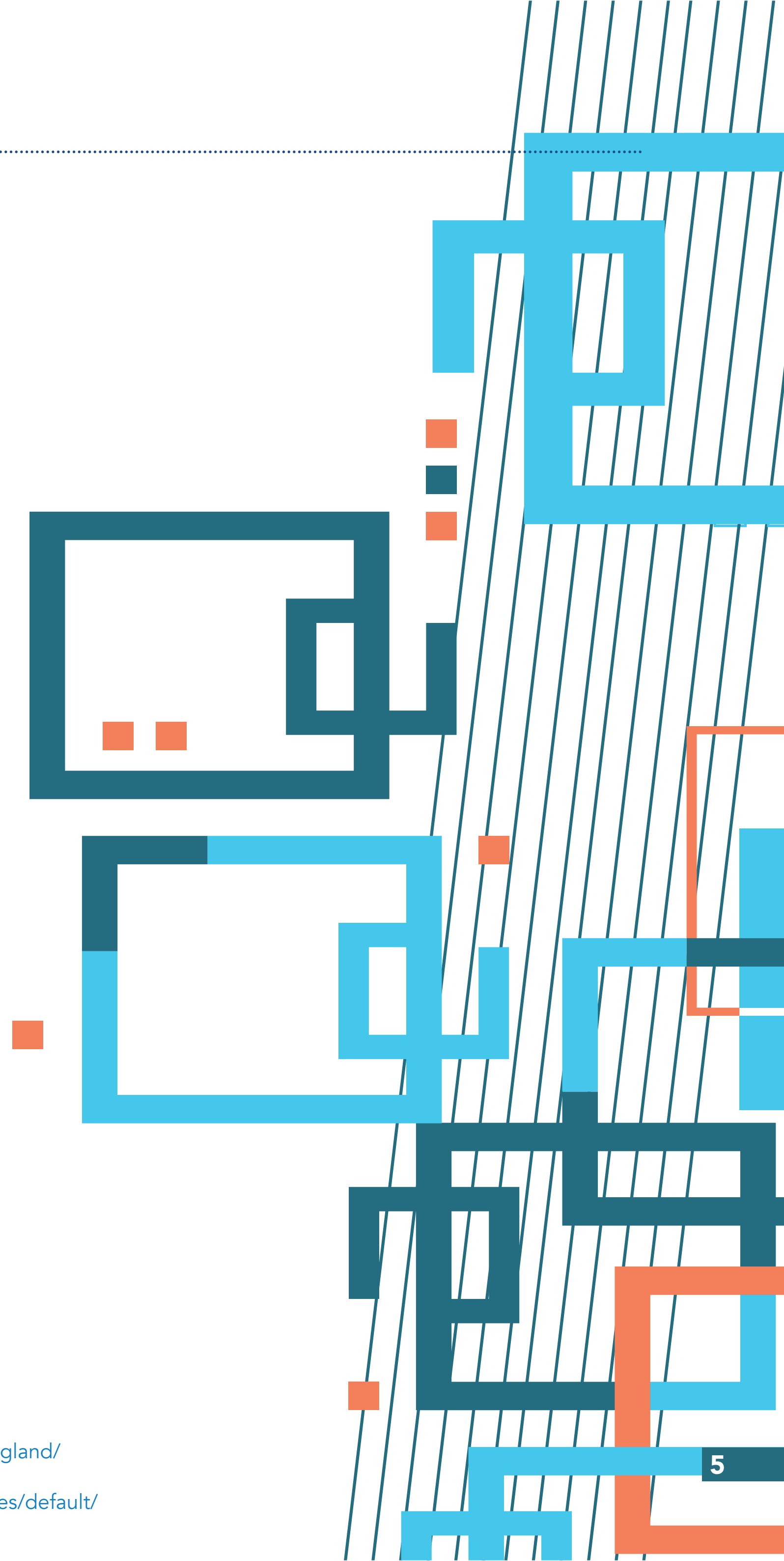
This is why it is so important that organisations that provide healthcare have robust quality assurance and improvement mechanisms. When implemented effectively, these inform and support frontline staff to deliver high-quality and sustainable care, and managers to make more intelligent and effective decisions[2].

It is equally important that board members and senior managers understand key principles of quality assurance and improvement and are equipped to apply these to their decision-making processes.

Given this, and to help board members navigate these challenges, Perfect Ward and the Good Governance Institute have partnered on a new programme of work focusing on quality assurance and improvement in health and social care.

This research paper is the first output from that programme. It aims to explore some of the key concepts of quality assurance and improvement and provide best practice examples and tools to support boards to translate theory into practice. The report has been informed by interviews and a roundtable involving senior figures from the health and social care sector.

We would like to thank everybody who contributed to this paper, especially the members of the editorial board and those we interviewed. The full list of contributors can be found in the appendix.



[1] The NHS Constitution for England (updated 1 January 2021): https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

[2] Anna Dixon, Catherine Foot, Tony Harrison, Preparing for the Francis Report, The King's Fund, 2012 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/preparing-for-the-francis-report-jul2012.pdf

2. Context

Health and social care systems across the world are grappling with a range of similar problems, including staff recruitment and retention challenges, developing more integrated care systems, achieving financial sustainability, and, of course, ensuring that health and care services are accessible and high-quality.

In the UK, and in England in particular, health and social care is in a period of considerable change. Ever since the publication of the Five Year Forward View in 2015, we have seen the gradual rolling back of legislation that emphasises competition as the main driver of improving quality of care and financial sustainability, in favour of that which prioritises integration, collaboration and partnership. This has culminated in the recent publication of NHS England's ***Integrated Care Systems: Design framework***, which sets out how NHS leaders and organisations will operate with their partners in integrated care systems (ICSs) from April 2022[3]. These changes will result in the dissolution of clinical commissioning groups as ICSs are formally created around the country, as well as the introduction of provider collaboratives and place-based governance arrangements. All of this will have implications on how care is delivered and assured, with new layers of governance required.

Other parts of the UK are arguably somewhat further along on the integration journey[4]. Scotland legislated for integrated care in 2014, bringing health and social care under the management of 31 integrated authorities. Also in 2014, Wales introduced integrated health and social care partnerships consisting of local government, NHS, third and independent sectors, and carer representatives. Whereas across Northern Ireland there are 17 integrated care partnerships that bring networks of service providers together to provide more joined up care for local populations.

At the same time as we are seeing widespread system-level changes introduced and embedded, health and care organisations around the world have also been responding to what has been called an 'unprecedented challenge' in the COVID-19 pandemic[5]. This has pushed many organisations and their staff, who have worked commendably throughout, to the brink[6]. The impact on quality of care is hard to quantify but certainly poses a significant near-term risk to many organisations in the sector.

For many NHS organisations, the pandemic represented a period when governance was rightly relaxed in order to release precious time and capacity to the Covid response. During this period, we have seen committees deemed to be less essential stood down, regulatory intervention significantly reduced, and many services put on hold[7]. It demonstrated what was possible, particularly with regard to digital transformation, with increases in virtual consultations and remote working.

Now, as we come out of the worst of the pandemic, health and social care providers have a rare opportunity to recast quality governance within their organisations. In doing so, it will be important that the learning from the previous 18 months is embedded and, where appropriate, paused activities reintroduced.

[3] NHS, Integrated Care Systems: design framework, version 1, June 2021 https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf
[4] GGI, Growing pains: integrated care lessons from Scotland and Wales, Illumination series, March 2021 https://www.good-governance.org.uk/publications/insights/growing-pains-integrated-care-lessons-from-scotland-and-wales
[5] Ham, C (2020). The challenges facing the NHS in England in 2021
[6] GGI, Practical solutions for managing NHS system burnout, Illumination series, April 2021 https://www.good-governance.org.uk/publications/insights/practical-solutions-for-managing-nhs-system-burnout
[7] GGI, Purposeful quality committees, Illumination series, June 2021, https://www.good-governance.org.uk/publications/insights/purposeful-quality-committees

3. The current state of play

This section will cover what quality assurance and quality improvement actually mean and entail, as well as their roles in healthcare systems domestically and across the world.

3.1 What is quality assurance

Quality assurance is the function of setting standards for things, measuring whether the standards are met and what the variation is and trying to iron out unwarranted variation, principally."

– a chief executive at our roundtable

The IHI describes six dimensions of quality that must be in place for the delivery of high-quality healthcare: safety, effectiveness, patient-centredness, timeliness, efficiency, and equity[8]. It is up to boards, managers, and ultimately all staff to ensure that these dimensions are in place with health and social care organisations through a process of quality management.

The major force behind quality management was Frank Winslow Taylor, whose 1911 book *The Principles of Scientific Management* set out the key principles of quality assurance. In 2001, the Academy of Management voted this the most influential management book of the 20th century.

The premise of quality assurance is that work can be codified as a series of instructions and standards.

Within this, it is important that organisations, including board members, understand the extent of their responsibilities for the provision of safe and effective care.

In the UK, public and private providers of health and social care are subject to the same tests and standards including a duty of quality.

"The board has a key role in safeguarding quality, and therefore needs to give appropriate scrutiny to the three key facets of quality – effectiveness, patient safety and patient experience.

Effective scrutiny relies primarily on the provision of clear, comprehensible summary information to the board, set out for everyone to see, for example, in the form of quality accounts[9]."

Quality assurance, then, which relates to the "processes for defining, assuring, maintaining and improving quality", is essential to ensuring boards fulfil this duty[10]. Implemented effectively, quality assurance should also increase the transparency, relevance and value of information that organisations disclose to their market and their stakeholders.

3.2 What is quality improvement (QI)

It is a mistake, I think, to see QI as the next step on from QA. They're symbiotic things. You need both. I wouldn't want to have a blood transfusion that wasn't very heavily quality assured. I wouldn't want to set up a community outreach service if I hadn't empowered the staff to be perpetually improving or changing. It's that."

– a chief executive at our roundtable

'Quality improvement' in healthcare is the framework used to systematically improve the ways care is delivered to patients, using characteristics that can be measured, analysed, improved and controlled.

[8] IHI, How Can We Define "Quality" in Health Care?, http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/DefiningQualityAimingforaBetterHealthCareSystem.aspx
[9] NHS, The Healthy NHS Board: Principles for Good Governance https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-TheHealthyNHSBoard.pdf
[10] Dixon A, Foot C, & Harrison T, Preparing for the Francis report: How to assure quality in the NHS

Quality improvement arose in the 1920s through pioneers such as Juran and Deming at the Hawthorne Works in Cicero, Illinois. It is underpinned by the belief that those with the best knowledge of how to improve work efficiency are those that are actually doing it: the teams at the sharp end.

In healthcare we see this pioneered through the Institute of Healthcare Improvement (IHM), for example, with techniques such as LEAN or the 'Plan-Do-Check-Act' (PDCA) cycle[11]:

It involves continuous efforts to achieve stable and predictable results, in essence, to reduce process variation and improve the outcomes of these processes both for patients and the healthcare organisation and the system it works in[12].

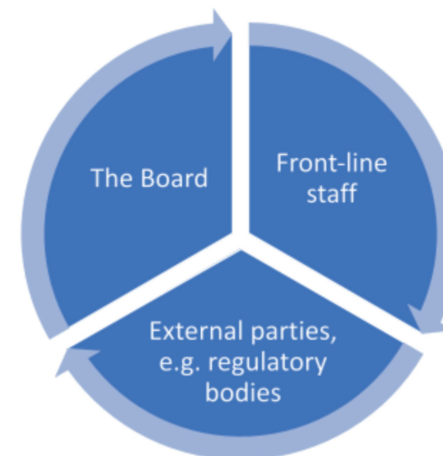
3.3 Reassurance versus assurance

In governance, great emphasis is placed on distinguishing between reassurance (when someone tells you that all is well) and assurance (telling you what's happening and showing you the evidence so that you can judge for yourself if all is well), and boards must be careful to ensure that they strike the right balance between the two[13].

This will allow boards to not be overrun by statistics and also ensure that they are not solely reliant on what the executives say is happening.

In healthcare, it is frequently argued that there are 'three lines of assurance' or 'three lines of defence' when it comes to quality[14][15]. At the first level are the healthcare professionals responsible for the delivery of patient care.

At the second level are boards who retain ultimate accountability for the quality of care within their institutions. And at the third level are external bodies such as regulatory organisations which are typically responsible for assuring the public about the quality of care they should expect to receive[16].



Those working at each level have a fundamental role to play in ensuring that healthcare services are safe and effective. However, this paper is principally concerned with the second level of assurance: boards and the systems and processes which support their effective functioning.

[11] ASQ, What is the plan-do-check-act (PDCA) cycle? https://asq.org/quality-resources/pdca-cycle
[12] Agency for Healthcare Research and Quality, Practice Facilitation Handbook https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod4.htm
[13] GGI, Assurance, Reassurance and Performance, Illumination series, May 2021 https://www.good-governance.org.uk/publications/insights/assurance-reassurance-and-performance
[14] Agency for Healthcare Research and Quality, Practice Facilitation Handbook https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod4.html
[15] NHS Providers, Board assurance: a toolkit for health sector organisations
[16] Dixon A, Foot C, & Harrison T, Preparing for the Francis report: How to assure quality in the NHS

GGI has previously written about how the best boards continually question their own governance[17]. This includes how information is presented and utilised within board and committee meetings to ensure that board member time and expertise is most effectively utilised.

But how much assurance is the right amount? And how can boards truly be confident about the quality of services being provided?[18]

It is our view that, at a time when many of our colleagues are concerned with capacity and staff health and wellbeing, we should be wary of returning to the assurance industry that has historically existed within the management structures of most health and social care providers – and which is resource-intensive and often confused with good governance.

To resolve this, it is important that boards put in place the right systems and processes to support staff to report and manage quality[19]. This includes the implementation of digital solutions to help mechanise assurance process as well as appropriate escalation routes, with staff at the front line dealing with the day-to-day issues, but escalating any areas of concern through the organisation. A key principle must be that only the areas of greatest concern are escalated to the executive, with less concerning issues dealt with at the appropriate level. This ensures proper accountability.

3.4 Specific responsibilities of healthcare organisations with regards to quality of care

NHS boards have a statutory duty of quality. In support of this, the Leadership Academy suggests the following to exhibit good practice:

- All board members need to understand their ultimate accountability for quality.
- There is a clear organisational structure that clarifies responsibility for delivering quality performance from the board to the point of care and back to the board.
- Quality is a core part of main board meetings, both as a standing agenda item and an integrated element of all major discussions and decisions.
- Quality performance is discussed in more detail regularly by a quality committee with a stable, regularly attending membership.
- The board becomes a driving force for continuous quality improvement across the full range of services.
- Boards are also required to endorse and sign off declarations of assurance to regulators in relation to quality, and comply with the registration requirements of the quality regulator.[20]

On the other hand, ensuring accountability in relation to quality is facilitated by more than regular scrutiny of information on quality, however exemplary it may be. Research suggests that governance of quality can be improved if board members routinely step outside the boardroom to gain first-hand knowledge of the staff and patient experience. It is important to ensure that clinical leaders are properly empowered to lead on issues relating to clinical quality, as boards benefit from regular opportunities both to take advice from clinical leaders and to reflect on innovative practice in relation to quality improvement[21].

3.5 Regulation and stakeholders

A high-performing quality assurance framework helps ensure that healthcare organisations perform at an optimal level.

[17] GGI, The basics of good governance, Illumination series, May 2021, https://www.good-governance.org.uk/publications/insights/the-basics-of-good-governance
[18] GGI, Assurance, Reassurance and Performance, Illumination series, May 2021 https://www.good-governance.org.uk/publications/insights/assurance-reassurance-and-performance
[19] GGI, Purposeful quality committees, Illumination series, June 2021 https://www.good-governance.org.uk/publications/insights/purposeful-quality-committees
[20] NHS, The Healthy NHS Board: Principles for Good Governance https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-TheHealthyNHSBoard.pdf
[21] Ibid

Without it, managers would have a less clear view of how patients are being treated while under their care, staff performance levels, and outcomes for both patients and the organisation. The demonstration of a robust quality assurance framework and evidence of quality improvement are staples among the expectations of regulatory bodies in the health and social care sector. Failure to meet these demands is likely to result in dire consequences for any organisation and could warrant further investigation.

Many organisations in the UK are involved with quality assurance, the King's Fund lists, among others:

- **The Care Quality Commission** – responsible for licensing all providers of health and social care. It has the power to close services down if they are below standard.
- **The National Institute for Health and Clinical Excellence** – its main function in the present context is to produce clinical guidelines. It has been charged with defining quality standards for the treatment of a wide range of conditions.
- **The Commission for Healthcare Regulatory Excellence** – responsible for overseeing all the professional regulators. It reports annually on their performance and in some circumstances can override their decisions.
- **The General Medical Council** – responsible for registering doctors when they enter the profession, for making arrangements for dealing with poorly performing doctors, and, currently, for introducing a five-yearly system of revalidation.
- **The Nursing and Midwifery Council** – responsible for registering nurses, nursing associates and midwives when they enter the profession and for dealing with poorly performing nurses and midwives.
- **Health and Care Professions Council** – responsible for regulating 15 health and care professions such as dieticians, clinical scientists and paramedics in the UK.
- **General Dental Council** – the UK-wide statutory regulators of the dental team.

Internationally, the following organisations play a role:

- **Institute for Healthcare Improvement (IHI)**
- **International Society for Quality in Health Care (ISQua)**

As well as other country-specific bodies such as:

- **Health Quality Ontario**
- **Australian Institute of Health and Welfare**
- **Council for Health Service Accreditation of Southern Africa**

3.6 Regulatory requirements for quality

Under Regulation 12 of the CQC's Guidance for Providers, the following are listed as essential in terms of providing safe care treatment:

a. assessing the risks to the health and safety of service users of receiving the care or treatment;
b. doing all that is reasonably practicable to mitigate any such risks;
c. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
d. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;
e. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way;
f. ensuring the proper and safe management of medicines;
g. assessing the risk of, and preventing,

detecting and controlling the spread of, infections, including those that are healthcare associated;

The quality assurance system within an organisation should ensure that such standards are monitored and maintained.

However, failure to meet these standards is likely to warrant further action from the CQC upon inspection, either in the form of a demand for improvement or direct intervention.

The CQC is likely to check:

- if policies are relevant, up-to-date and accessible
- if operations are patient-centred
- risk assessments
- staff satisfaction surveys
- if important documents are stored in a safe and secure place
- documented evidence of improvement
- improvement action plans
- culture
- ISO accreditation
- if there is a robust overview of the care that is being provided[22].

In a similar fashion, the Australian Commission on Safety and Quality in Health Care stipulate requirements that include:

- That health service organisation uses organisation-wide quality improvement systems that:

a. identify safety and quality measures, and monitor and report performance and outcomes
b. identify areas for improvement in safety and quality
c. implement and monitor safety and quality improvement strategies
d. involve consumers and the workforce in the review of safety and quality performance and system[23].

- That health service organisation has organisation-wide incident management and investigation systems, and:

a. supports the workforce to recognise and report incidents
b. involves the workforce and consumers in the review of incidents
c. uses the information from the analysis of incidents to improve safety and quality
d. regularly reviews and acts to improve the effectiveness of the incident management and investigation systems.[24]

- That health service organisations:

a. have processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care
b. have processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems
c. use this information to improve safety and quality systems.[25]

[22] Citation, Quality assurance and good governance: how to be outstanding https://www.citation.co.uk/news/care/quality-assurance-good-governance-outstanding/
[23] Australian Commission on Safety and Quality in Healthcare, Patient safety and quality systems, Action 108 https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-108
[24] Australian Commission on Safety and Quality in Healthcare, Patient safety and quality systems, Action 111 https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-111
[25] Australian Commission on Safety and Quality in Healthcare, Patient safety and quality systems, Action 113 https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-113

It is important to mention that within the independent sector, regulatory requirements deemed fit for national health systems may not translate well to independent healthcare providers. Nuffield Health had the following to say on the matter:

"The progress has not always been easy, as much of the existing best practice guidance relates to NHS services and does not necessarily translate across to the situation in the independent sector. And initially it took time to work with CQC to ensure they understood exactly how our services were configured."[26]

Beyond regulatory matters, management also needs to be able to demonstrate a sound understanding of quality assurance systems from the top down. HealthMangagement.org has outlined seven leading practices in relation to the board and its role in regards to quality assurance:

1. **Leadership for Improving Quality and Safety**: actively demonstrating a commitment to seeking assurance and driving improvement.
2. **Practices for Improving Quality and Safety**: making quality and safety of care a priority of the board's business
3. **Partnerships for Improving Quality and Safety**: developing strong collaborative partnerships with staff, service users and the wider community
4. **Methods for Improving Quality and Safety:** support the provider in applying a quality improvement methodology
5. **Measurement for Improving Quality and Safety**: selecting board measures to monitor and demonstrate an improvement in the delivery of care.
6. **Risk Management and Assurance**: ensure that all risks to service user quality and safety are addressed in a robust and structured way.
7. **Planning for Improving Quality and Safety**: championing and overseeing the development, implementation and monitoring of a plan for improving quality and safety.[27]

[26] Nuffield Health, Working with the Care Quality Commission, 2018, https://www.nuffieldhealth.com/article/working-with-the-care-quality-commission-cqc

[27] HealthManagement, Volume 18 Issue 2, Quality and Safety: The Role of The Board, 2018, https://healthmanagement.org/c/healthmanagement/issuearticle/quality-and-safety-the-role-of-the-board

4. Changes to the healthcare environment and the impact on quality assurance and improvement

As highlighted earlier in this report, health care services around the world are increasingly adopting integrated approaches to the delivery of care.

In the UK, health and social care in England is currently going through a period of fundamental change. This will result in the introduction of ICSs, provider collaboratives and other place-based arrangements which will, at least in the short term, complicate quality governance and assurance.

The recently published ***Integrated Care Systems: Design Framework***, consolidates NHSEI's thinking around ICSs and particularly focuses on the governance of these new bodies. It proposes a two-board model consisting of:

- ICS NHS body, which is comprised of NHS organisations and is responsible for the day-to-day running of the ICS
- ICS Partnership Body that brings together a wider array of stakeholders including social care and public health

The Framework also makes plain that from their establishment in April 2022, ICSs will be expected to have specific responsibilities for delivering safe and high-quality services.[28] In particular, the ICS NHS body will be the accountable body for the realisation of this, underpinned by effective governance and strong local leadership.[29]

In tandem, other home and international countries are seeing a similar focus on more joined-up and integrated care. For example, since the passing of the 2014 Public Bodies (Joint Working) (Scotland) Act, Scotland has required local authorities and health boards to work together to plan and deliver adult community health and social care services, including services for older people.[30]

Integration Joint Boards have been introduced to facilitate this process, commissioning health and care services for specific regions and consisting of councillors, NHS NEDs, non-voting NHS professionals, the third sector and service users.

Further afield, Australia's long-term health plan sets out the vision for the country over the next 10 years. It focuses on developing a system that is more integrated, efficient, focused on patients, and equitable. Six integrated care programmes and initiatives have been developed that focus on improving population outcomes:

- Planned Care for Better Health
- ED to Community
- Residential Aged Care
- Paediatrics Network
- Specialist Outreach to Primary Care
- Vulnerable Families.[31]

Similarly, in Canada, provinces such as Ontario have piloted a range of integrated care initiatives such as integrated funding models (IFMs) that required collaboration and coordination across acute and post-acute care sectors. These are reported to have had a positive impact on care coordination across healthcare settings.[32]

Those we spoke to broadly agreed with the move towards integrated care systems

[28] GGI, ICS oversight - good governance arrangements will be key, Illumination series, July 2021 https://www.good-governance.org.uk/publications/insights/ics-oversight-good-governance-arrangements-will-be-key
[29] GGI, ICS design: good governance will be key, Illumination series, June 2021, https://www.good-governance.org.uk/publications/insights/ics-design-good-governance-will-be-key
[30] GGI, Growing pains: integrated care lessons from Scotland and Wales, Illumination series, March 2021 https://www.good-governance.org.uk/publications/insights/growing-pains-integrated-care-lessons-from-scotland-and-wales
[31] NSW Government, Australia's Long-Term Health Plan, 2019, https://www.health.nsw.gov.au/integratedcare/Pages/australias-long-term-health-plan.aspx
[32] Gayathri Embuldeniya, Jennifer Gutberg, Walter P.Wodchis, The reimagination of sustainable integrated care in Ontario, Canada, January 2021, https://www.sciencedirect.com/science/article/pii/S0168851020302736

and the opportunities that this presented for improving quality. This includes improved relationships and coordinated care across areas, opportunities for sharing and learning from best practice, staff movement, and more standardised and aligned measurement.

Despite this, some of those we spoke to in preparing this report suggested that some lingering issues persist. In England this includes:

- concerns that ICSs will be too acute focused with historical issues remaining around parity of esteem for mental health trusts and others around the system including adult social care services
- the risk that new arrangements will add layers of bureaucracy and governance and increase duplication
- the need for regulation will need to adapt as ICSs and place-based arrangements increasingly come into being.

Some of these issues will be addressed through the introduction of clearer governance and accountability as ICSs are brought into being on a statutory footing. However, strong leadership will also be required if quality of care is not to be impacted during the transition.

In speaking to colleagues from around the world, several highlighted the importance of the following in ensuring that health and social care integration programmes have a positive impact on quality and safety:

- clear lines of responsibility and accountability between organisations, underpinned by robust joint governance (see below on the principle of subsidiarity)
- strong relationships and mutual trust between organisations and individuals
- consistent and clear reporting around quality across organisations
- a transparent and open culture which supports staff and organisations to learn from their mistakes coupled with mechanisms to share this learning across systems.

4.1 The principle of subsidiarity

"To embed innovation, you need to give staff permission to try and come up with their own solutions"

– a chief executive at our roundtable

Key to clearer and more effective governance across ICSs and place-based arrangements is the principle of subsidiarity.[33] This is the concept that decisions and accountability are best delivered with the greatest impact as close to the front line in a system or organisation as possible.

It is an approach that has long been adopted in the EU, which has a formal principle of subsidiarity in policymaking, and is increasingly gaining traction in the NHS.[34] For example, the Health and Social Care Select Committee has argued that systems:

…should be encouraged to adopt a principle of subsidiarity in which decisions are made at the most appropriate local level."[35]

The principle of subsidiarity particularly makes sense with regards to quality assurance and improvement which require the impetus and initiative of front-line staff to work effectively. It requires organisations to clarify those quality incidents that require escalating to board level and those that can and should be resolved at the front line or as close to it as possible.

It also requires greater levels of trust from leadership teams and accountability among staff teams, as well as engagement across sectors and services.

[33] GGI, Place in integrated care: the noble aim of subsidiarity, Illumination series, July 2021 https://www.good-governance.org.uk/publications/insights/place-in-integrated-care-the-noble-aim-of-subsidiarity
[34] The Strategy Unit, What could NHS policy makers learn from the European Union? 2019 https://www.strategyunitwm.nhs.uk/news/what-can-nhs-learn-eu
[35] www.parliament.uk, Health and Social Care Select Committee, 2018, https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/65017.htm

High quality and real-time data and electronic decision-making tools can support this principle in health and social care settings by giving staff the tools to identify and resolve potential quality issues as they are developing.

Health and social care boards should ask themselves the following questions with regard to quality assurance and subsidiarity[36]:

- Where does quality assurance currently sit in our organisation? Does this support the principle of subsidiarity?
- How does technology and data support decision-making across our organisation?
- Does the leadership team champion data?
- Do staff understand data as a decision-making tool to improve organisational culture or as something which is used punitively?

[36] GGI, People in Place, 2021, p.15

Essential characteristics of subsidiarity

Clear vision

- A clear shared vision that is understood at all levels within an organisation or system

Trust

- Genuine trust and commitment from all levels to all the principles of subsidiarity and a respective appreciation of the functions exercised at various levels

Culture

- All levels of the organisation are not only respected but also required to assume responsibility and accountability for whatever they are able to do on their own initiative
- Application on subsidiarity based on the context and circumstances of a particular capacity, decision or place
- Autonomy to work towards shared objectives
- Flexibility to move capacity down levels if those below could perform certain functions

Initiative

- Employees and less senior groups must assume responsibility and accountability for doing whatever they can on their own, by taking the initiative and developing an entrepreneurial spirit
- The scope, limit and reach of each individual, team or service's sphere of influence is recognised

Support

- More senior staff taking responsibility for the providing resources and training necessary for lower levels to discharge their functions
- More senior staff providing opportunities for learning and growth when mistakes are made and not reverting to centralised approaches if errors occur

Power

- The principle of subsidiarity means giving real power to lower groups for them to work towards shared aims
- Senior groups should not prevent or absorb any responsibilities that can be discharged by a lower level

Circumstances

- Subsidiarity needs to be applied in each case through consideration of all relevant circumstances or a particular place or decision, meaning the way it is applied in practice may differ widely from one situation to another

Data transfers

- These approaches need to be supported by effective transfers of information from one level to the next, allowing senior levels to support where necessary and to create open communication across various levels to cultivate trust and strong relationships

4.2 Regulation

The future of regulation is less clear. We have already highlighted how regulation is a key element of quality assurance.

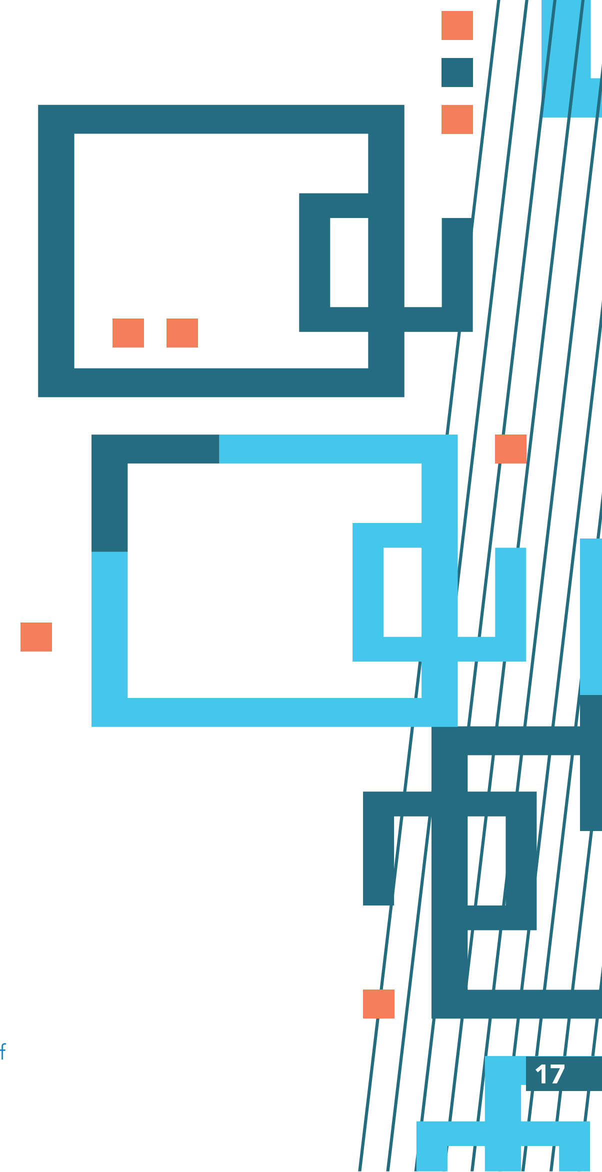
NHS Providers has recently raised concerns from its members that 'the existing regulatory frameworks do not sufficiently reflect the context in which they are now providing care or their organisation's contribution to the wider health care system.'[37]

Indeed, the CQC has acknowledged that its regulatory framework will need to change and has experimented with place-based reviews and a new well-led framework.[38][39] NHSE has also highlighted how it expects the system oversight to work with ICS NHS Body responsible for local oversight and assurance.[40]

This is an approach that has been followed in the other home nations for some time. For example, in Scotland, Healthcare Improvement Scotland and the Care Inspectorate have been conducting joint inspections of some services since 2013.[41] Whilst in Wales, The Healthcare Inspectorate Wales and Care Inspectorate Wales have conducted joint inspections of care for people with learning disabilities and community mental health teams.[42]

Interviewees were clear that regulatory changes must support quality improvement and assurance initiatives not stifle them. In order to do this, it has been suggested that the following will be key:

- not creating additional regulatory burdens for individual organisations through system and regulatory accountability
- focusing on quality improvement rather than punitive interventions
- ensuring greater transparency around methods and reporting
- not adopting a one-size fits all approach.[43]



[37] NHS Providers, NHS regulation: a shifting focus, 2019 https://nhsproviders.org/news-blogs/blogs/nhs-regulation-a-shifting-focus
[38] Care Quality Commission, An update on CQC's regulatory approach, 2021 https://www.cqc.org.uk/news/stories/update-cqcs-regulatory-approach
[39] Care Quality Commission, Our reviews of local health and social care systems, 2019 https://www.cqc.org.uk/local-systems-review
[40] NHS, Integrated Care Systems : design framework, June 2021 https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf
[41] York Health Services and Delivery Research, January 2020 https://www.york.ac.uk/media/crd/Protocol-reg-inspec-integrated-care.pdf
[42] Ibid, https://www.york.ac.uk/media/crd/Protocol-reg-inspec-integrated-care.pdf
[43] NHS Providers, NHS Regulation: a shifting focus, 2019 https://nhsproviders.org/news-blogs/blogs/nhs-regulation-a-shifting-focus

5. Acknowledged enablers and barriers

This section considers some of the key current enablers and barriers to effective quality assurance, as highlighted by our NHS, independent sector and international colleagues in interviews.

This is not intended as an exhaustive list but it is presented as a means of demonstrating the breadth of factors that can impact on quality assurance and in order to support board members in the implementation of effective quality assurance systems and processes.

This section will cover:

- board member expertise
- governance
- culture
- workforce - specifically, capacity and leadership
- digital technology and data literacy and
- engagement.

5.1 Board member expertise

All board members are ultimately accountable for the quality of services provided by their organisation. It is therefore vital that they have a good understanding of quality, supported by robust governance systems and processes. The board should set the tone and be the driving force for continuous quality improvement across the organisation.[44]

NHS boards in the UK adopt a unitary model, whereby executive and non-executive directors jointly serve on the same board. In this mode, both executive and non-executive board members bear equal accountability for the quality of services provided by the trust. In Europe, the unitary board model also exists in, for example, The Netherlands, Norway and Sweden.[45]

In interviews, we were told that a significant proportion of health and social care NEDs have a non-healthcare, often commercial or financial background. While it is obviously important that boards are diverse and incorporate a range of skill sets and, indeed, NEDs are often specifically appointed to bring a skill or perspective not currently available to the board, we were told that this can sometimes create an imbalance within boards and, in turn, a reduced understanding and challenge around quality and quality assurance issues. Regulators recommend that at least one non-executive director in NHS trusts has a clinical background.[46] Many of those we spoke to felt it was important that board members had a 'lived experience' of healthcare, either through personal or vicarious experience, to keep the board focused on trying to do the right thing for as many people as possible.

In the past, this has been counteracted by initiatives like site visits; however, for obvious reasons, these have been drastically reduced during the last 18 months. So boards have had to become more reliant on what they hear from regulators and stakeholders to scrutinise and challenge the narrative presented at committee and board meetings without visiting or speaking with frontline staff, as they would have pre-COVID.[47] Those we spoke to were clear that such initiatives were vital to board quality assurance and should be stepped back up as soon as possible.

[44] NHS, The Healthy NHS Board: Principles for Good Governance https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-TheHealthyNHSBoard.pdf
[45] Peter C Smith, Anders Anell, Reinhard Busse, Luca Crivelli, Judith Healy, Anne Karin Lindahl, Gert Westert, Tobechukwu Kene, Leadership and governance in seven developed health systems, 2021, https://pubmed.ncbi.nlm.nih.gov/22265340/
[46] Monitor, 2014, The NHS Foundation Trust Code of Governance
[47] GGI, Assurance, reassurance and performance, Illumination series, May 2021 (https://www.good-governance.org.uk/publications/insights/assurance-reassurance-and-performance)

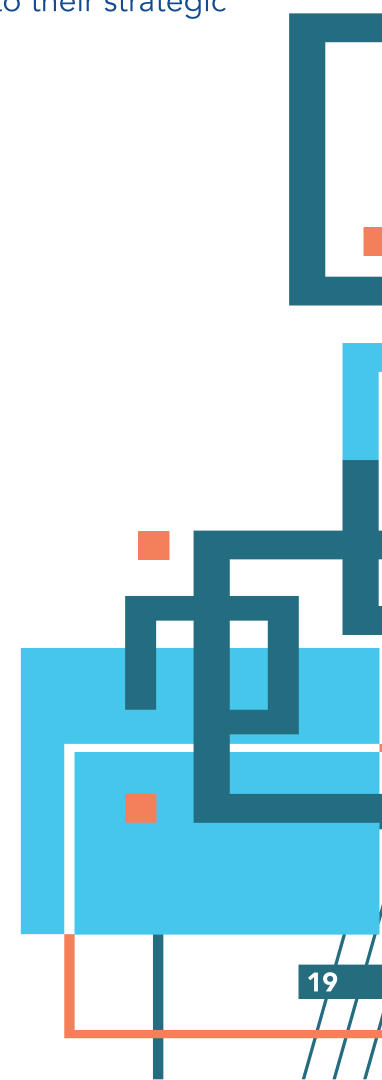
Others also highlighted that non-clinical NEDs can rapidly be brought up to speed through involvement in quality committees and quality-related activities. We are aware that many health and social care organisations actively appoint non-specialist NED chairs for their sub-committees (i.e. a NED without a clinical background to chair the quality committee) in order to prevent operational and assurance functions becoming blurred, as well as to provide a different lens and challenge to issues.

Furthermore, while it is important to ensure an appropriate balance of skills at board level (including in relation to clinical and non-clinical skills) it is equally important for the board to ensure that the clinical leadership of the organisation is effectively empowered to lead on quality governance, and provide the appropriate assurance of how this duty is being discharged, to the board.[48]

Similar issues were highlighted in our interviews with international colleagues. Canadian healthcare providers, for example, have a board consisting of independent governors intended to represent the communities that the provider serves. We were told that, where these governors had no clinical background, they often struggled to engage with quality items and were more reliant on reassurance from management that services were high-quality and effective.

In each instance, board member induction and development were highlighted as vital to quality assurance. It was suggested that both newly appointed board members, as well as those from non-clinical backgrounds, would benefit from coaching or mentorship to help them understand both what 'good' (and preferably 'excellent') looks like and what to look for when carrying out specific duties such as site visits. In particular, it was suggested that board members needed to have a sound grip on complex topics, such as health acuity, in a way that many currently do not.

These challenges also somewhat extend to executive directors. Those we spoke to highlighted that silo working persisted in many organisations, compounded by often contradictory messages from the centre. A particular example was provided around conflicting advice being given about the need for organisations to clear the significant elective backlog while also being told that, in order to achieve financial targets, they must close beds. Boards of organisations have to make difficult decisions and need to ensure that these are dictated, at all stages, by reference to their mission and values, linked to their strategic intent.



[48] NHS, The Healthy NHS Board Principles for Good Governance, p.12

5.2 Governance

I find as an executive, it's very easy to give too much detail, but if you give too much detail, non-execs will – and I'm sure I'd be the same – will go down rabbit warrens and miss the point. Our job is to make sure they have the right picture to have confidence in what's happening so they can make the right decisions and ask the right questions."

- a chief nursing officer at our roundtable

Boards need to ensure that they are effective in setting the right standards and gaining assurance that those standards are being met. Indeed, one of the key responsibilities of the board is around assurance 'that the organisation does what it says it will do and behaves in the manner it has agreed'.[49]

Interviewees from organisations across UK healthcare have all identified the need for boards and organisations to see quality assurance, enabled by good governance, as a holistic approach through which integrated reporting can be central.

Key questions for board members:

- Do we have sufficient quality expertise on our board to ensure adequate scrutiny and challenge around quality issues?
- Have we provided NEDs with sufficient induction and developmental support to ensure that they are comfortable contributing to discussions around quality issues?
- How do our board and committee reports support discussion and debate around quality issues?

Other key characteristics that have been highlighted through our engagement include:

- the board assurance framework (BAF) should assure the board what is happening across the organisation, balancing the need to provide enough detail to inform but not overload with information
- effectively sharing best practice internally, with and between other organisations and systems
- having the right governance systems and processes in place including committee structure and associated reporting on quality, integrated reporting and the appropriate amount of board time devoted to significant quality issues. This can be achieved through effective agenda management and reporting. Boards need to achieve this through the principle of delegation and can choose to establish quality committees to help the board understand quality issues and effectively fulfil its role around quality governance.[50]

In addition to ensuring the key elements above are fit for purpose, we suggest that boards routinely consider a series of key questions (developed through our conversations with interviewees) in assessing whether governance is delivering the right outcomes for the organisation or entity and ultimately the population it serves.

[49] GGI, Good Governance Handbook, 2015, p.7
[50] GGI, Purposeful quality committees, 2021

It is also paramount that healthcare organisations have forums at all levels where staff can share learning from both good and bad practice with colleagues. We heard an example of one health and social care provider implementing a system called Greatix (reporting examples of great work) to sit alongside their Datix (incident reporting system) with examples routinely shared at board and the quality committee. Others highlighted how each sub-committee and management forum had best practice as an agenda item as a means of sharing lessons learned and positive work.

Patient safety summits are another mechanism through which this can be achieved, and we provide an example below how this might be introduced.

Patient safety summit example from Barking, Havering and Redbridge University Hospitals NHS Trust

The patient safety summit is a meeting attended by all staff disciplines (doctors, nurses, managers, students, allied health professionals, administrators, and a patient partner). It focuses on a serious or notable incident that has recently taken place at the trust. The meeting is chaired by either the medical director or director of nursing, and is open to wider staff attendance.

Key questions for board members:

- Does the board have the right systems in place to ensure it receives and utilises high quality data?
- Does the board use a range of improvement methods and are they fit for purpose?
- Does the board consider trend data for quality metrics?
- Does the organisation allow for open discussions around the lessons from incidents or near misses?
- Is the board sighted on and have confidence in timescales for further improvement?
- Has the board put in place specific actions (that are regularly reviewed) to ensure that, where the data indicates something is amiss, there is a closing of the loop?

5.3 Culture

We've got to create a culture where people feel safe to raise issues before they become a real problem."

– a chief nursing officer at our roundtable

The importance of culture was consistently highlighted by those we spoke to as central to effective patient care, safety and quality assurance.

What do we mean by 'organisational culture'?

This is a phrase that can often be difficult to pin down. It has been described as: 'the way things are done around here' by Watkins (2013), the attitudes, beliefs and behaviours of groups of people within organisations (Schien, 1985), or 'the vision, values and behaviours of an organisation and the people within it'.[51]

Key characteristics of organisations that embody a culture that allow for effective quality assurance, include speaking up and listening, or:

- knowing how to ask the right questions and what the right questions are
- providing and fostering the right environment through which individuals can answer truthfully
- having challenging conversations
- providing a safe space and environment that allows staff to speak up, or a 'blame-free culture'
- holding listening and action events
- looking at trends, not just information, around complaints and compliments
- testing against key cultural indicators around the provision of safe and effective care
- challenging sub-cultures when these function and influence in a manner that is contrary to the overall organisational mission and vision.

In order to foster an organisation or entity that has an open and transparent culture, boards of healthcare organisations and systems need to consistently ask themselves whether the right environment exists or has been created.[52] Deciding by which metrics an organisation can be assessed as having an 'open and transparent' culture is, however, challenging.

Where boards are not effectively asking these sorts of questions and monitoring organisational culture, the results are often dire. The failings at Mid Staffordshire NHS Foundation Trust are perhaps the most high-profile example in recent times, where an estimated 400 to 1,200 people died unnecessarily as a consequence of poor quality of care and a culture that enabled this.

Other examples include the failure to provide appropriate care in the provision of mental health services[53] and maternity services where a 'culture of blame' has shown to impact on the safety of the care provided.[54]

We suggest that boards routinely undertake simple diagnostic exercises in relation to testing staff confidence in organisational governance, as well as undertaking whole organisation culture and mindset surveys - in order for organisations to check-in and test against key elements of organisational culture.

[51] Nightingale, Adele (2018) Developing the organisational culture in a healthcare setting. Nursing Standard, 32 (21), p. 4-5
[52] GGI, Creating the right culture for integrated care, Illumination series, July 2021 https://www.good-governance.org.uk/publications/insights/creating-the-right-culture-for-integrated-care
[53] The Observer, Coroners warned of mental health care failings in dozens of inquests, September 2021 https://www.theguardian.com/society/2021/sep/05/coroners-warned-of-mental-health-care-failings-in-dozens-of-inquests
[54] BBC, Culture of blame holding back maternity safety, report finds, July 2021, https://www.bbc.co.uk/news/health-57725263

Indeed, reflecting on the experience of Mid Staffordshire NHS Foundation Trust, Professor Don Berwick, author of the seminal Berwick Report, argued that:

"The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."[55]

Where organisations have embraced such an approach, moving away from a punitive blame culture to one based on patient experience and learning, the results have been significant. One example of this is the experience of Mersey Care NHS Foundation Trust which we describe on this page.

More broadly, tools such as the annual NHS Staff Survey, as well as complaints and patient experience data, provide a useful barometer of trust culture and performance and should routinely be engaged with by the board.

We explore this further within this white paper through key elements of the maturity matrix, a practical self-assessment tool developed for boards to test their effectiveness in relation to this key consideration.

Mersey Care NHS Foundation Trust's Just and Learning Culture[56]

Recognising that a culture of openness, transparency and compassion was central to ensuring staff felt supported and empowered to learn when things did not go as expected, in 2016 Mersey Care introduced its Just and Learning Culture.

Drawing on the work of Professor Sidney Dekker, as well as other industries such as aviation and nuclear technology, the Mersey Care's Just and Learning Culture seeks to emphasise learning and improvement rather than to apportion blame for failings.

Before the introduction of this new approach, the trust had a high number of disciplinary processes and above average staff turnover. This was both resource and time intensive, and was also not good for staff engagement and morale. Since adopting its new approach, the trust has seen a 75% reduction in disciplinary investigations and a significant reduction in dismissals and suspensions, leading to substantial cost savings, despite the organisation more than doubling in size.

The Just and Learning Culture has been adopted by health care organisations across the world – for example, at the Ottawa Hospital in Canada.

[55] Don Berwick, National Advisory Group on the Safety of Patients in England, A promise to learn-a commitment to act, 2013, p. 5[48]GGI, Purposeful quality committees, 2021
[56] Mannat Kaur, Robert J. de Boer, Amanda Oates, Joe Rafferty, Restorative Just Culture: a Study of the Practical and Economic Effects of Implementing Restorative Justice in an NHS Trust, 2019

5.4 Workforce

5.4.1 Capacity

It should be all of our jobs to create an environment where people feel empowered to change, to do what they need to do for their patients and for us to put the systems and processes in place to enable that to happen. You can do that in a very large organisation if you get your systems and processes and your leadership right."

– a chief nursing officer at our roundtable

We know that the impact of COVID-19 on work has been pronounced. In many countries, staff have been asked to make significant adjustments; to swap the office for their living rooms, to forgo much of the social interaction that had been commonplace, and to cope with significant uncertainty both in their work and personal lives.

For healthcare workers, the impact has arguably been far greater, with many having also been asked to work in particularly challenging and, at times, potentially unsafe environments.

Key questions for board members:

- Has the right environment been created within our organisation to support quality improvement? How do we know?
- What metrics do we routinely consider at board and committee meetings? Do these provide us with the right intelligence to enable effective decision-making?
- Have we introduced a people and culture committee, or similar forum, to consider cultural and organisational development issues?

This has taken a significant toll on staff health and wellbeing.[57] In England, before the pandemic, the Office for National Statistics had already highlighted that sickness rates in the public sector as a whole were high, with workers in public administration, education and health recording some of the highest numbers across all sectors. For example, NHS sickness rates are twice the level than within the private sector, and staff in the NHS are 50% more likely to have high levels of work stress compared to members of the general working population.[58]

This is a pattern that is mirrored in many other countries. In Canada, for example, as many as 7 in 10 healthcare workers have reported worsening mental health during the pandemic and there are concerns about the impact of this on the sustainability of the workforce.[59]

Those we spoke to warned that such figures are likely to worsen in the coming months and that this would have an impact on the quality of care and governance. A lack of capacity was frequently raised as an issue, with staff often finding it difficult to carve out time to devote to clinical governance activities. There are also concerns that we may see an exodus of senior and clinical staff in the coming months. These are issues which are replicated across the system, however we heard that more locally issues around culture, training and development also presented challenges to effective quality assurance.

[57] GGI, Addressing the risk of moral injury, Illumination series, February 2021, https://www.good-governance.org.uk/publications/insights/addressing-the-risk-of-moral-injury
[58] West M., What does the 2019 NHS Staff Survey truly tell us about how staff needs are being met?
[59] Statistics Canada, Mental health among health care workers in Canada during the COVID-19 pandemic, February 2021, https://www150.statcan.gc.ca/n1/daily-quotidien/210202/dq210202a-eng.htm

5.4.2 Leadership

"We need to be very clear what all leaders, what every single person is responsible for in quality assurance and that they're trained to do that. It doesn't come naturally to people. Often people feel anti-assurance, they don't realise the value of that scrutiny and we need to make sure the training is right."

– a chief nursing officer at our roundtable

Although typically led by the director of nursing (with quality, data and systems and processes often sitting within their remit and responsibility) or the medical director, quality improvement and assurance should be seen as being part of everyone's role.

Healthcare Improvement Scotland suggests that "the embedding of quality improvement as an integral part of the everyday work of all staff" is crucial to the success of healthcare providers,while Paul Batalden argues that: "Making improvement happen…[requires an] unshakeable belief in the idea that everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it."[60]

Reflecting this, one of the key recommendations of the Berwick review is to:

"Give the people of the NHS career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning."[61]

This does not mean that all staff need to be expert in quality improvement and assurance approaches, rather that all have a role to play. NHS Improvement has developed the concept of 'dosing' to illustrate this.[62] The principle idea is that the methodology should be appropriate for the seniority and requirements of roles.

Within all of this, clinical leadership and engagement is of fundamental importance. For example, Healthcare Improvement Scotland's review of quality improvement models in healthcare finds that "the active engagement of health professionals [in QI], particularly doctors," is vital to its success.[63] Similarly, research by Walshe and Offen into the lessons from the experience of Bristol Royal Infirmary argues that "strong clinical leadership is perhaps the most important single determinant of the progress of clinical quality improvement in healthcare organisations."[64] Clinical leaders should be both well regarded and have sufficient time to commit to a leadership role.[65]

[60] PB Batalden, and F Davidoff, What is "quality improvement" and how can it transform healthcare?
[61] Don Berwick, National Advisory Group on the Safety of Patients in England, A promise to learn-a commitment to act, 2013, p. 5
[62] Institute for Healthcare Improvement, Building capacity and capability for improvement: embedding quality improvement skills in NHS providers
[63] Healthcare Improvement Scotland, A systematic narrative review of quality improvement models in health care
[64] K Walshe, and N Offen, A very public failure: lessons for quality improvement in healthcare organisation from the Bristol Royal Infirmary
[65] Ibid.

5.5 Digital technology and data literacy

High quality data is essential to effective quality assurance. Interviewees made plain that digital technology, coupled with increased staff digital and data literacy, were clear enablers for improved quality assurance.

For example, occurrence screening – a method for monitoring the quality of clinical practice – comprehensively demonstrates how digital technology can elevate assurance to new realms of certainty. However, a large number of organisations within health and social care still operate on a paper basis, for their quality audits.

Even the most highly trained and diligent humans make errors. However, implemented appropriately, digital technology can provide more systematic and comprehensive processes. This is already beginning to be seen within many healthcare organisations which are pioneering advanced digital systems.

Those we spoke to also highlighted the value of technology, including smartphone apps, to provide real time data and assurance on the effectiveness of care quality. Dynamic data displayed through new digital systems can transform the way individuals work – we were given examples of doctors being motivated when shown a series of data of where they stood in comparison to others. Transparency with information via real-time digital platforms can be transformative.

Key questions for board members:

- Have we seen a deterioration in quality of our clinical data?
- If so, what steps are being taken to ensure that staff have time and resources to devote to quality improvement and quality assurance activities?
- How are we ensuring that quality improvement and quality assurance activities are not siloed within certain individuals?

But it goes much further than this. As an enabler and assurance tool to improve performance and quality, many described the availability of real-time data as revolutionary to patient care because it means clinicians and organisational leaders can make decisions based on what is happening there and then, rather than trying to make shifts based on historical data. For example, The Royal College of Physicians used the first few years of electronic observations at Portsmouth Hospitals Trust to help create the National Early Warning Scores (NEWS) (RCP, 2012). Other benefits to using real-time data include: reduced mortality, reduced infections, improved compliance (in relation to electronic recording of observations), reduced workload, improved governance, improved resource deployment etc.

In implementing such systems and processes, a key hurdle remains digital literacy as well as the incorporation of appropriate IT capabilities within hospital and care settings. Behaviour change is therefore a key part of integrated digital assurance systems. Many praised the immediacy of feedback that digital systems can provide but commented that people who have been working with a slow feedback mechanism for a long time may not know how to react. Organisations will need to work with their staff not only to integrate the systems themselves but also to help them to adapt to reacting in the moment and making

immediate improvements. Co-design of the systems with those clinical staff who will be using them is often a sensible first port of call.

This also relates to how boards themselves use and interact with technology and data. Board members should feel confident interrogating the data in order to adequately challenge what they are being told by management and in order to be assured, rather than reassured. We were told that having access to live dashboards and integrated performance reporting was helping in this regard.

Key questions for board members:

- How comfortable are board members and our broader staff with interrogating quality data?
- Where we have introduced new digital quality assurance or improvement solutions have we socialised these with staff? Are our staff suitably trained to use these systems?

5.6 Engagement

"Co-production and involvement… sometimes…sounds like a time-consuming process for patients or carers to become involved with but actually, it should be something straightforward. For example, it is about how can you capture people so you can have your learning moment as a trust from the widest group as possible rather than the people who have the time during the day to come to meetings."

– a director of quality at our roundtable

Effective engagement (staff, patient and otherwise) is a central tenet of robust quality assurance. It is vital in ensuring that all perspectives are being considered in quality improvement and assurance approaches and for the benefits of engagement with both staff and patients to be realised, which can positively affect quality, safety and performance.[66]

It is now widely accepted that patients should be involved in discussions on their treatment and their own health and care in a meaningful way. Indeed, in England, Clinical Commissioning Groups (CCGs) and NHSEI have duties under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) to promote the involvement of patients in their own health and care.[67] To be able to do this, the correct engagement channels between the clinicians and organisations providing care and patients must be in place. The benefits of involving people in their own health include improved health and wellbeing, improved care and quality, improved financial sustainability and enabling the efficient allocation of resources (as well as being a legal duty).[68]

Similarly, when considering an effective quality assurance programme it is, therefore, absolutely key that feedback from staff, patients, carers and their families is factored in.

[66] Leadership and engagement for improvement in the NHS, Together we can, Report from The King's Fund Leadership Review 2012
[67] Involving people in their own health and care: Statutory guidance for clinical commissioning groups and NHS England, p.5
[68] Involving people in their own health and care: Statutory guidance for clinical commissioning groups and NHS England, p.12 - 17

As the King's Fund reported:

"In a review of the US literature on collaboration between staff and leadership teams, Burns and Muller (2008) (taken from Rumbold et al 2015) reported that a key distinguishing feature between high and low-performing hospitals was 'the level of both hospital executives' and physicians' behavioural skills."[69]

Health and social care organisations have specific duties in law to involve stakeholders in decision-making. This is especially so when such decisions will impact upon them. Boards and governing bodies should ensure that they use sound social science techniques to understand the views of stakeholders. This should also help boards better understand the risks to their strategic goals, as poor stakeholder relationships are a potent cause of failure to achieve strategic goals such as service reconfiguration or changes in care pathways.

This has become arguably more important than ever during the COVID-19 pandemic, which has seen issues of inequality surfacing even more starkly, with particular concerns for BAME communities and the differential experience they often have. Indeed, the Berwick Review argued that the patient voice should be heard "in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety."[70]

Key questions for board members:

- Have we considered how we will engage effectively with our staff and the public in a post-pandemic world? Has this considered the needs of all the populations that we serve?
- How is engagement information and data harnessed in board and committee meetings? Does it have a meaningful impact on decision-making?
- How comfortable are board members in considering and utilising qualitative data?

Boards have several mechanisms through which they can understand the staff and patient voice. These include site visits and walkabouts, patient stories, the NHS Staff Survey and, in the case of NHS Foundation Trusts, the Council of Governors.

Digital advances, particularly during the pandemic, have also arguably made engagement easier than ever before. The use of teleconferencing software such as Zoom or Microsoft Teams has allowed for simpler and greater information sharing within staff groups. Many health and social care organisations are also increasingly harnessing social media to drive engagement in a systematic and recurring fashion. This extends to inter-organisational engagement as well.

As highlighted earlier in this paper, we know that during the previous 18 months, the COVID-19 pandemic has had a considerable impact on the extent to which boards have been able to incorporate such activities into their pattern of working. This in turn has limited the extent to which they are able to triangulate the information presented within board papers and increasingly means that NEDs have to rely on reassurance from executives. Recognising this, there is an urgent need to step these back up as soon as possible, and we are aware that many organisations are already exploring mixed approaches to staff and patient engagement.

[69] S Atkinson et al., Defining quality and quality improvement

[70] Don Berwick, National Advisory Group on the Safety of Patients in England, A promise to learn-a commitment to act, 2013, p. 18

High Reliability Organisations

An example given was from one of the health systems in Canada, which started a journey of shifting its organisation to a high reliability organisation through robust staff and community engagement. What worked particularly well in this model was the safety huddles that were put in place. The system went through a process of training all 13,000 staff on high reliability principles and tried to drive and instill a culture of safety where people could feel that they could speak up for safety.

The huddles are focused on four quadrants: quality, safety, efficiency and engagement, and bring together both the trained staff voice and engagement in order to drive quality assurance and improvement, as well as to ensure that the patient voice is at the centre of everything that is being done.

Characteristics of high reliability organisations (HROs).

- Don't be tricked by your success – constantly challenge your ways of working, your expected outcomes and the messages coming back to the organisation.
- Defer to your experts on the front line – your staff are the people who can spot problems, opportunities for improvement and can apply their expertise to tackle changing conditions. Robust assurance does not mean knowing everything about the intricacies of your business – it means knowing that the right people are able to recognise, deal with and report issues when they occur.
- Let unexpected circumstances provide your solution. Resist the temptation to focus on one aspect of a complex problem or what you did last time – new circumstances may provide new solutions and organisations need to be open to this challenge. This, of course, goes hand in hand with deferring to front-line experts.
- Embrace complexity – healthcare staff often bemoan the frequent analogies made with aviation and other industries on safety. "We are different, we are much more complex," they say. While healthcare is certainly different and analogies can only be taken so far, complexity exists in different ways in many businesses and sectors. Complexity should foster adaptability and a culture of listening to the experts and other stakeholders. HROs resist simplification and seek to understand nuance.
- Anticipate – but also anticipate your limits. This is where you need to get the balance right between strategy and planning and acting. This is a lesson that organisations need to take on board in the wake of the potential for post–Francis paralysis. Weick and Sullivan recommend focusing on those mistakes you wish to avoid. How do you know what these are? What do systems tell you about them? Secondly, trust your intuition to enable you to act but check the accuracy of your estimated outcome as soon as you can. Did this change of policy work? Where is the evidence? Do we need to adjust it? And also, how can we build in resilience so that these actions are measurable and reproducible in the future?

6. Maturity Matrix

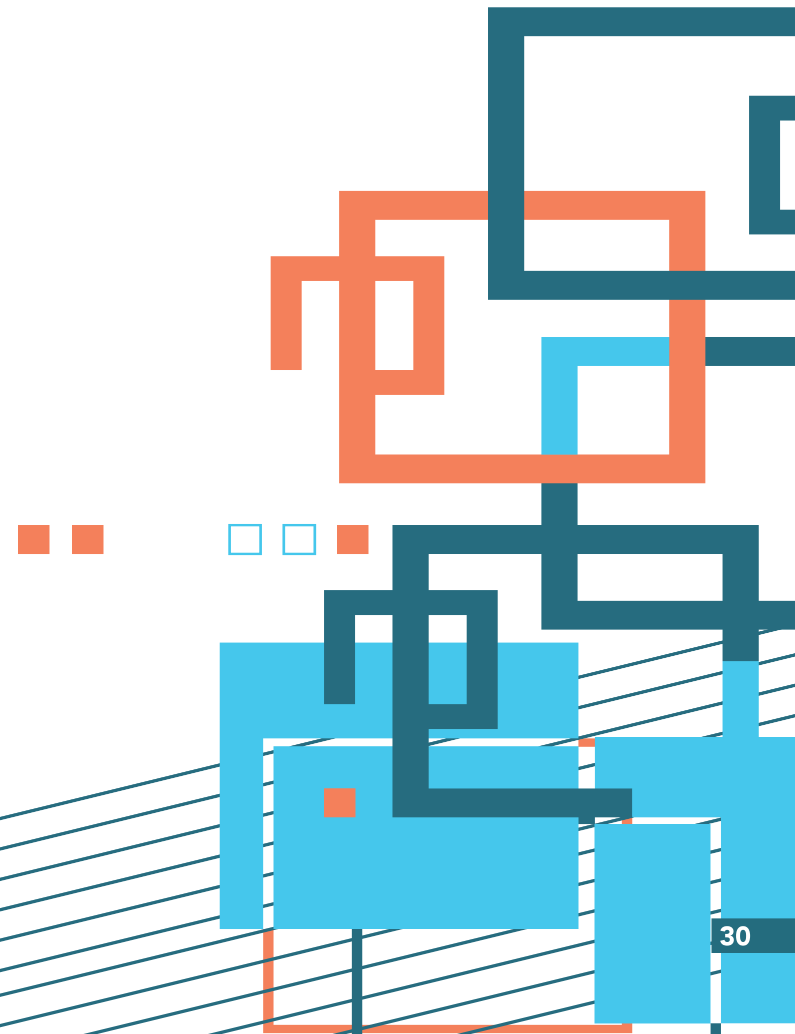
This maturity matrix is a resource designed to support organisations to self-assess whether they are appropriately applying the key principles of good governance practice in relation to quality assurance.

It describes the key elements of quality assurance along the y-axis, and graduations of 'maturity' along the x-axis. For each of the key elements, we have identified indicative statements so that organisations can self-assess their level of 'maturity'. The rate of progress is incremental and the organisation cannot progress to the next level of maturity unless all criteria from the previous box have been fulfilled and, importantly, can be evidenced.

The matrix should be used to illustrate current performance and to inform and agree future developmental expectations. For example, an organisation may identify that it is currently at 'level 1' in regard to 'board reports and debate', and aspires to reach 'level 2' within the next year. The tool can then be used to inform and track improvement over the defined development period.

It is designed to foster discussion and constructive challenge at board level, before a consensus on the current self-assessment and future aspirations can be reached.

Importantly, an organisation may not necessarily be at the same stage for each of the key elements identified.



ENABLING QUALITY ASSURANCE

A Maturity Matrix for healthcare provider boards

TO USE THE MATRIX: IDENTITY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS

PROGRESS LEVELS ▶ KEY ELEMENTS ▼	1	2	3	4	5	6
LEADERSHIP & STAFF ENGAGEMENT	All staff are made aware of their responsibility to embed, deliver and assure high-quality services, for example through induction, mandatory training and corporate communications.	Staff roles and responsibilities are reiterated through personal development plans, job descriptions and structured feedback sessions. Team effectiveness initiatives are in place with emphasis placed on ensuring there is combined capacity for quality assurance activities.	Staff have protected time to undertake quality improvement or assurance activities and are empowered to identify and make improvements in their own areas of work. The organisation is open and responsive to staff concerns, contributions and feedback.	Quality assurance data is comprehensive, current and widely accepted as accurate. Appropriate forums exist for staff to learn from this intelligence, and for staff to receive structured feedback.	The organisation is able to evidence how it consistently and effectively supports the development of its staff with regards to quality improvement and assurance, for example, with internal or external training programmes.	The leadership of the organisation is recognised internally and externally for its work on quality improvement and assurance leading to better outcomes.
DIRECTOR DEVELOPMENT	Quality assurance and supporting processes are included in board member induction programmes.	Board members routinely engage in training and developmental activities with regards to quality in health and social care.	All board members can confidently explain the organisation's approach to quality assurance and improvement.	External review confirms the quality of board member knowledge and contribution with regards to quality.	Board members contribute to peer review and development activities in other similar organisations around quality improvement and assurance.	The board is recognised as an exemplar whose work is promoted nationally with regards to quality improvement and assurance.
BOARD REPORTS AND DEBATE	Board meetings have quality as a core agenda item. It is considered and referenced in relation to all board decisions.	There is a clear reporting structure in place linked to the organisation's quality assurance framework. The board assurance framework clearly identifies associated risks to quality against set strategic objectives.	All board members understand their accountability for quality and contribute to debate. The board looks at trends in relation to quality to inform discussions and decision-making, not just for information.	Integrated reporting is in place. The board has challenging and constructive discussions in relation to quality, when needed.	Board scrutiny is seen as an important and highly effective lever for driving quality improvement.	The board shares its experience in quality improvement to share best practice and enable learning for other organisations.

ENABLING QUALITY ASSURANCE

A Maturity Matrix for healthcare provider boards

TO USE THE MATRIX: IDENTITY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS

PROGRESS LEVELS ▶ KEY ELEMENTS ▼	1	2	3	4	5	6
ENGAGEMENT OF PATIENTS, RELATIVES AND CARERS	The organisation understands the importance of involving patients, relatives and carers in quality improvement and assurance activities and plans, and has affirmed its intention to do so. Basic patient feedback, such as friends and family test is also collected.	A strategic plan and approach is in place to engage with patients, relatives and carers. This plan is aligned with board understanding and approach and embedded in core committees.	Representatives of patients, relatives and carers contributed to the development of the quality strategy and other related strategies. There is a structured approach to collect patient and stakeholder feedback and this is consistently considered at board and other committees.	Patient experience and complaints targets are being met. Patients, relatives and carers are confident in the receptiveness and effectiveness of the organisation and this is reflected in the results of local and national surveys.	Patients, relatives and carers play a proactive role in all decision making – supporting and influencing strategic priorities and approach. Also, they are part of the quality improvement methodology.	External recognition of the approach taken to stakeholder and patient voice – publications seen and other organisations following exemplar lead.
USING DATA	Across the organisation, there is an understanding of the important role that quality data plays in driving improvement with regard to the quality of care.	The board and its quality committee regularly scrutinise the evidence from the organisation's digital QA system. Staff are empowered through training to properly utilise data to drive improvement.	IT systems and information governance protocols support the easy sharing of information and data, and this is routinely used to guide decision-making.	The board has confidence in the quality of its data and there is evidence that this is used effectively and consistently by operational managers and the board to drive forward the performance of the organisation.	Quality assurance data is used to escalate and address issues proactively at an early stage.	The organisation is regarded as a national exemplar with regards to the approach taken to digital assurance and supports.
QA METHOD	We have agreed process standards for quality assurance.	We measure the standards and scrutinise variation. Hypotheses for variations have been established.	We have created an effective action plan to address variations in quality.	The process for ongoing measurement has contributed to a perceptible reduction in variation to the standard. We benchmark our performance with others.	We learn from other organisations and implement best practice wherever practical.	Others learn from our organisation. We are a national leader in terms of removing unwarranted variation.

7. Conclusion

Quality assurance is vitally important in health and social care organisations around the world. It ensures that boards, managers, and health and social care staff can be confident in the quality of services being provided and in turn the health and safety of those in their care.

As we have discussed, quality assurance is different from quality improvement in that one is about understanding the quality of services being provided whereas the other is about processes being in place to systematically improve services. The former informs the latter and forms the focus of this report.

Despite its importance, quality assurance is not always undertaken effectively within health and social care providers. This is for a range of reasons including:

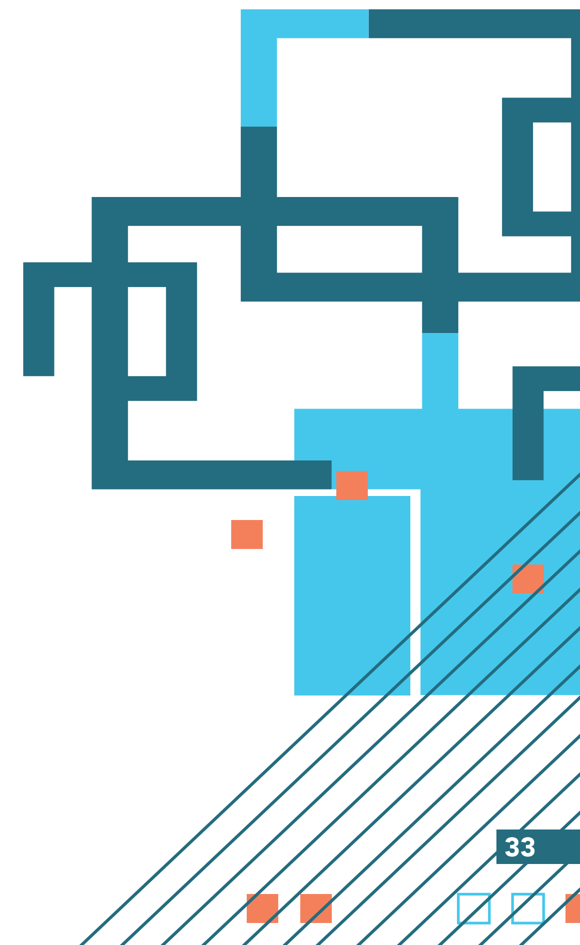
- mixed board member expertise
- ineffective governance
- organisational culture
- skills and capacity issues
- the extent to which digital technology is embraced and harnessed
- a lack of stakeholder engagement.

Our report has explored these issues in more detail with the aim to highlight potential pitfalls for organisations seeking to improve their quality assurance, shine a light on best practice examples and case studies, and provide a series of key questions that board members (and others) can ask themselves when trying to assess their quality assurance capability. These are relevant to those operating in a range of countries and sectors.

The report also examined the implications of increasing integration of health and social care services around the world. Using England and the development of integrated care systems as an example, we highlight how regulation will need to change and make the case for greater awareness and application of the principle of subsidiarity.

This report has been developed as a practical guide for board members to be able to achieve effective quality assurance within their organisation - and use the supporting maturity matrix as a tool to enable further maturity development.

We recommend that boards use the maturity matrix routinely during a set period of time (e.g. every 12 months) as a means to clearly capture progress and agree next steps in achieving their desired objectives.



Appendix

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- Ashley Chengadoo, National Quality Manager, Life Healthcare
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