FROM WARD TO BOARD

Identifying good practice in the business of caring

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The King's Fund>

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Having worked as both a clinician and a manager, Sue's particular interests lie in developing clinical leaders and managers who can use reflection and creativity to make a sustained impact on service quality. She is also passionate about enabling human relationships to work across professions, groups, organisations and systems. She has an abiding interest in the development of the European Union and its impact on health and social care.

Sue was the Director of The King's Fund/Johnson and Johnson Nursing Leadership Programme from 1999 to 2003 and has co-directed the European Strategic Leadership programme with Insead, Athena and all the programmes for senior medical staff. She is currently Co-director of the Top Manager programme. She also directs the Successful Nurse Leader programme, the Burdett Trust Nurse Executives Board Leadership project and the Seattle Overseas Study Tour. Sue does team, organisational development and consultancy work as well as executive coaching.

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Katy has a PhD in organisational theory from Imperial College. The subject of her thesis was organisational learning, and communication and teamwork in the offshore drilling industry. She was specifically interested in how the industry could learn about safety incidents and the importance of a safety culture at the top, which ensured that 'the right information reached the right place at the right time'. Katy's first degree was in Social Anthropology at Cambridge.

Acknowledgements

Foreword

Caring for patients is the key 'product' of the business of health care, and we make no apology for describing it as such. Bringing the leadership of caring and the leadership of business together to improve people's experience of health care was the central objective of the *Who Cares, Wins* report (OPM 2006) commissioned from the Office for Public Management by the Burdett Trust for Nursing. Now, this objective is being taken forward and developed by The King's Fund in partnership with the Trust. By working intensively with a small but diverse sample of boards and their nurse executives, we are building a picture of what good practice in the business of caring looks like. As 'work in progress', this report identifies emerging themes from the first phase of the programme, and key questions to be addressed in the second phase, during 2009.

The Burdett Trust for Nursing is delighted to be working with The King's Fund in making a significant contribution to supporting nurse executives and their boards in achieving not just good but best practice in the business of caring for patients.

Ray Greenwood
Sue Norman
Trustees, Burdett Trust for Nursing

Summary

Failure to deliver the fundamentals of care can bring down an NHS board faster than failures of either finance or performance, and there have been recent examples of this. Despite this, there are still serious concerns about the lack of attention some NHS boards pay to the quality of clinical care. However, there have been considerable changes to the external environment over the past year, culminating in the *NHS Next Stage Review*, led by Lord Darzi (Department of Health 2008). This gives support to the improvement of the quality of care being a business imperative.

Such emphasis poses particular challenges for nurse executives. On the one hand, they are well placed to help boards assure themselves about the quality of clinical care. Yet when there are high-profile failings in patient care, it is often nurse executives who are blamed for failing to champion quality and patient safety at board level.

The King's Fund, in partnership with the Burdett Trust for Nursing (a charity that offers grants to support the nursing contribution to health care), has developed a programme of work to support nurse executives and NHS trust boards to 'bring the ward to the board'. It is about turning the spotlight firmly on to reviewing clinical quality, and putting patients and how they experience health care at the heart of an organisation's work. It set out to explore the role of nurses on the board and how far they were able to influence boards to increase the level of engagement with clinical quality.

This report presents the findings from the first phase of the programme, which was based on seven pilot sites across the UK. The sites included two foundation trusts, a partnership trust, and a primary care trust in England, as well as one site in Northern Ireland, one in Wales and one in Scotland. These pilot sites were chosen for the learning they could contribute about the role of the nurse executive in relation to high-quality, board-level clinical engagement, as well as how to manage patient care and improve the quality of the patient experience. The next phase of the programme, working in another six sites, is already under way and its findings will be reported later in 2009.

Lessons learned about clinical engagement by NHS boards

Based on our observations at the seven pilot sites, the following factors are emerging as important in enabling boards to engage effectively in clinical quality.

- **Having the right building blocks in place.** We have identified three key building blocks: the right information; recognition of the importance of relationships combined with robust governance arrangements; and strong clinical leadership and clinician engagement. The absence of any one of these will prevent boards from focusing effectively on the business of caring.

- **Embedding assurance of clinical quality across the organisation**. This relies on having the right processes in place and the right relationships to achieve continuous quality improvement. Boards require a robust assurance framework, which enables

timely and reliable clinical information to be reported to the board as a matter of routine.

- **Having a strong financial footing and a readiness to respond to the changing external environment.** Being in good financial health makes it easier for boards to ensure that finance does not dominate the agenda. We also observed the benefits that a period of stability at board level can have in supporting the development of strong, strategically focused governance.

- **The availability of certain types of information, which can help to kick-start a conversation about clinical quality at board level.** Effective boards give information on clinical quality high priority on the agenda and allow sufficient time for debate. However, there is a great deal of uncertainty around what types of clinical information boards want and need to scrutinise for assurance purposes. Based on our observations, we have identified five principles that underpin good information on clinical quality (*see* p 20).

- **Chairs and chief executives who work together to reinforce the importance of clinical quality.** The lead given by the chair and chief executive dictates how boards prioritise and treat the clinical quality agenda. We observed the benefits of a close working relationship between chair and chief executive, where each has a complementary style, and where both share an interest in clinical quality.

- **Making it explicit that clinical quality is an issue for the whole board.** Boards that have taken steps to develop a dedicated strategy for clinical quality, or have already set strategic objectives, are ahead in their thinking about embedding the right assurance processes.

- **Where boards rely on other structures (such as sub-committees) to provide assurances about clinical quality, there are clear and effective flows of information from these to the board.** The extent to which boards delegate their clinical engagement function, and how they do so, is difficult to assess. Moreover, it is unclear whether board assurance processes can ever be sufficient where clinical quality is not a feature of mainstream reporting at board level.

- **Demonstrating the learning environment by valuing and acting on feedback on the patient experience, including complaints and incidents.** Our observations suggest that boards too often shy away from discussing patient experiences that reflect negatively on the organisation. The substance of complaints was rarely discussed, and interest in patient safety incidents tended to be limited to issues of liability and corporate risk.

- **Demonstrating openness and transparency to public scrutiny at board meetings.** Boards need to resist a tendency to use 'part two' of meetings, held in private, to discuss difficult patient experiences. Closing down opportunities for such discussion in public undermines the board's ability to reassure external audiences that it is a learning organisation, focused on clinical quality.

- **The role of the chair in creating a climate and culture in which the patient experience can be discussed openly.** This also requires acknowledging any discomfort this may cause the organisation. Nurse executives who have successfully articulated patient experiences attributed this to the board's openness to receive such information.

- **Having non-executive directors who constructively challenge executive colleagues and seek assurances that clinical quality is embedded across the organisation.** At the pilot sites, the power of non-executives to question and meaningfully challenge

their executive colleagues was directly linked to the quality of the data they received. Where they received good-quality data, non-executives were instrumental in making the links between different aspects of the business and clinical quality, and in specifying the type of data they needed in order to assure the quality of clinical care.

Lessons learned about the role and capabilities of the nurse executives

Our observations suggest that nurse executives have a key role to play in:

- helping to create the right culture and climate to have open discussions about quality
- leading by example and constantly reinforcing the importance of clinical quality to all aspects of the business
- stimulating discussion about what types of information boards want and need to know in order to assure quality
- presenting, analysing and interpreting hard data and identifying the clinical impact of that data
- serving as a conduit of information about the patient experience through the use of soft intelligence and compelling narrative
- helping boards to tap into the emotional content of the patient experience
- role-modelling appropriate behaviours around presenting and receiving negative feedback from and about patients.

From our observations, the following capabilities are important if nurse executives are to work effectively with boards to secure improvements in clinical quality.

- **Having excellent communication skills and being able to talk convincingly about the business of the whole organisation, and not limit their contributions to clinical issues.** Nurse executives at the pilot sites who were observed as having impact in the boardroom were able to talk convincingly about the business of the whole trust, and how clinical quality fitted into this strategically. Where nurse executives limited their contributions to clinical issues, they were more likely to believe that they were defined primarily by their nursing background and to feel sidelined in the boardroom in comparison to their finance colleagues.

- **Being able to draw on a wide range of capabilities, employing a style, tone and body language that reflect authority, confidence and competence.** One of the most important competencies is developing 'emotional intelligence' in order to discuss difficult clinical issues with credibility. Nurse executives need to consider the language used to present the patient experience and to avoid use of business-oriented metrics that fail to accommodate the emotional content of patients' stories.

- **Being able to draw on financial and commercial acumen, but also retain their clinical focus and emphasis on the human experience.** One of the most valuable aspects of the nurse executive role is the potential to serve as a conduit of information about the realities of the patient journey and to 'bring the ward to the board'. Where we observed nurse executives successfully fulfilling this role, this was in part attributable to their use of 'soft intelligence'. Presence on the 'shop floor' and nurturing relationships with nursing staff in wards and departments were key elements of this.

- **Being able to nurture key alliances, both within and outside the boardroom, which support them to be more confident and authoritative in discussing clinical quality at board level.** Nurse executives who enjoyed good support from their chief executive were able to be more confident and more commanding of respect,

and more courageous and open in the information they brought to the board. The good relationships and mutual support we observed between nurse executives and their medical director peers had the potential for even greater impact on the quality agenda at board level. It was clear from the pilot sites that nurse executives within different organisations share similar challenges, highlighting the potential for developing networks across NHS organisations.

We also found that to be effective nurse executives needed to be **supported by robust reporting processes around clinical quality and a boardroom environment that is open and interested in this agenda**. Where we observed an authoritative nurse executive, the board was usually characterised as having robust reporting processes around clinical quality, or at least a strong focus on the issues.

The second phase of the programme, working with another six sites in 2009, provides an opportunity to explore these emerging themes in more depth.

Introduction

The ability of nurse leaders to manage patient care and improve the patient experience has received increasing attention in recent years, specifically in relation to healthcare-associated infections (HCAIs). High-profile failings in patient care have often led to nurse executives being blamed for failing to champion quality and patient safety at board level.

In 2007, the Burdett Trust for Nursing, a charity that offers grants to support the nursing contribution to health care, commissioned The King's Fund to develop a programme of work to support nurse executives and NHS trust boards to bring 'the bedside to the boardroom', or 'the ward to the board'. The programme builds on the results of two pieces of work commissioned by the Burdett Trust and carried out by the Office for Public Management (OPM 2006) and the University of Plymouth (2006), which examined the ability of trust boards to focus on the 'business of caring' and the role of nurse leaders in supporting this.

What has been coined the 'business of caring' is, or at least should be, an issue for the whole board, rather than just the responsibility of the nurse executive. It means that patient satisfaction and customer care should be as important as financial and performance targets. It means turning the spotlight firmly on to reviewing clinical quality and responsiveness to patients – in other words, putting patients and how they experience health care at the heart of the organisation's work.

This desire for a greater focus on clinical quality is not new. *Governing the NHS: A guide for NHS boards*, produced by the NHS Appointments Commission (2003), states that: 'It is the duty of the Board to ensure through Clinical Governance that the quality and safety of patient care is not pushed from the agenda by immediate operational issues.' Ministers have also clarified the responsibilities of the top team: 'It is the Chairs and the Chief Executives that are in the firing line. Let there be no doubt that their role is to assure themselves that their organisation is giving appropriate attention to safety and quality' (Hunt 2007).

However, there have been longstanding concerns about the attention NHS boards give to quality compared with the attention devoted to finance (this is somewhat unsurprising, given the prevailing climate of NHS deficits and a policy of naming and shaming NHS trusts in debt). The handling of HCAI illustrates well the tensions that can occur. More than a third of trusts told the Healthcare Commission that they had experienced difficulties in reconciling the management of HCAI and cleanliness with the fulfilment of financial targets (Healthcare Commission 2007).

What *is* new is that a focus on clinical quality has now become a business imperative. The external environment has changed since the 'ward to board' programme began in 2007. As Lord Darzi's *NHS Next Stage Review* (Department of Health 2008)says, the quality of care should be 'the basis of everything we do in the NHS'. Defining quality care as 'clinically effective, personal and safe', there is now much greater emphasis on systematically measuring and publishing information about the quality of care (including patients' views on the quality of their experiences), as well as measures of safety and

clinical outcomes. The quality of the patient experience will have a direct impact on the way providers are funded, and there is to be greater investment in clinical and board leadership. It is on clinical and board leadership that this programme focuses attention, and on nurse executives in particular.

The added value of nurse executives

The post of nurse executive was established with the first wave of NHS trusts in 1991. The structure of the NHS has evolved considerably since then, but the principle of nurse executive involvement has remained. Foundation trusts are required, as a legal minimum, to have a registered nurse or midwife among their executive directors (Department of Health 2006a). In Wales, every local health board should have a nurse director, and in Scotland, a nurse executive director should be a member of all NHS boards and special health boards (Royal College of Nursing 2005).

However, nurse executive representation at board level is not always a statutory requirement, and there is some evidence that the role is less well established where there is no such requirement. For example, the Department of Health 'expects' the boards of each new primary care trust (PCT) and strategic health authority (SHA) to include a director-level nurse. The Royal College of Nursing (RCN) has identified a number of problems with nurse executive involvement in these settings. For instance, some SHAs have a named nurse but this individual is not represented at executive level; and many PCTs have not established a position equivalent to the nurse director role in NHS trusts (Royal College of Nursing 2005). One study of the remuneration of executives in PCTs found that, of the 28 nursing directors for which information was obtained, only 57 per cent were board-level posts (Pay and Workforce Research 2002).

Nurses are involved in all of the components of clinical governance, from patient involvement and clinical audit to staffing and staff management. They therefore have considerable power to influence patients' experiences of care (Fradd 2004). Nursing directors often have lead responsibility for many, if not most, of the key elements of the clinical governance agenda. A survey by Employing Nurses & Midwives (2005) found that 60 per cent of nursing directors had lead responsibility for clinical governance. Other key responsibilities include quality/performance (53 per cent), patient services (34 per cent), clinical services (32 per cent) and operations (30 per cent).

It is this breadth of focus, combined with accountability for nursing staff and the quality of nursing, that makes the nurse executive role so invaluable. The nurse director has the potential to bring to the board an unparalleled understanding of the nurse's role and a particular focus on the standard of clinical care that is being provided in the trust.

Who Cares, Wins, the report of a study carried out by the Office for Public Management (OPM) on behalf of the Burdett Trust for Nursing, found that the increasing breadth of nurse executives' responsibilities makes them well placed to lead the business aspects of patient care on behalf of their boards: 'Executive nurses have a critical role to play in enabling their boards and organisations, whether they are commissioners or service providers, to view the "business of caring" as much a part of their agenda as the financial bottom line' (OPM 2006). The trend for nurse executives to have operational responsibilities for clinical services puts them in a good position to influence business decisions and take an overall business perspective. Nurse executives have the potential to look across all of the decisions taken by the board and reflect on how these will affect the patient experience and the standard of patient care.

The size and breadth of portfolio for nursing directors carries other advantages. Much of nurse executive's authority is derived from the other 'corporate' roles that they hold;

the more corporate their role and more extensive their portfolio, the greater weight their input might have when discussing the clinical agenda. Limiting their input to a one-dimensional nursing portfolio may, in fact, limit their impact at board level.

On the other hand, there is a danger that nurse executives can become too thinly spread. The OPM report warned that the widening and increasingly complex portfolio of responsibilities given to nurse executives could see their focus on nursing care 'diluted or overshadowed by wider organisational concerns' (OPM 2006). Similarly, Fradd (2004) commented that the diversity of senior nurse roles could result in them being unable to focus sufficiently on key priorities. She remarked: 'In the case of Directors of Nursing the lack of an appropriate balance between the strategic role, leading nursing and being responsible for operational matters has not infrequently left them isolated and the target of blame.'

Challenges for nurse leadership

Being the target of blame as a nurse executive was brought sharply into focus by the Healthcare Commission's investigation into the outbreaks of *Clostridium difficile* at Stoke Mandeville Hospital (Healthcare Commission 2006). It was reported that senior nurses felt that their concerns were ignored by the nurse executive, who was criticised for demonstrating a lack of interest in the quality of nursing care and patient care, and for failing to represent nurses' concerns to the board, despite having lead responsibility for safety.

Such criticisms have invited wider questions about the ability of nurse executives to deliver the necessary leadership around patient care (*see*, for example, Wells *et al* (2006) and Taylor (2007)).

The White Paper, *Making a Difference* (Department of Health 1999), recognised the need to invest in clinical leadership development for nurses. It called on NHS organisations to ensure that decision-making in the NHS was properly informed by nursing knowledge. It also highlighted a need for particular attention to be given to developing nursing leadership in primary care settings, to ensure an effective contribution to the planning and commissioning of services.

A number of nurse leadership courses have been developed in recent years, including The King's Fund Successful Nurse Leader programme, which was designed to help senior nurses develop the skills, awareness and confidence they need to maximise their leadership potential. Until now, however, little attention has been given to supporting nurse executives to develop competencies specifically related to championing clinical quality at board level.

Development programme for nurse executives and trust boards

Against this backdrop, The King's Fund, with the support of the Burdett Trust, has undertaken a programme of work that focuses on how nurse executives are helping boards to assure themselves about the quality of clinical care, and the potential to develop this role further. The programme aims to:

- support nurse executives and their boards by giving feedback to identify good practice and to explore, facilitate and develop models for high-quality, board-level clinical engagement
- review and interpret this work for a wider audience
- disseminate learning to a wide audience and encourage adoption of best practice.

The programme is based on the working hypotheses that, where nurse executives are able to enhance the performance of the board in relation to clinical issues, there are valuable lessons about the role and attributes of the nurse executive, and also lessons about the types of board (structure, processes and behaviours) that best enable the nurse executive to make an effective contribution.

The key components of the programme are as follows.

- **Diagnostic site visit.** Initial individual meetings with the nurse executive, chief executive, chair and medical director, followed by a joint meeting with all four participants. The key aim of this initial diagnostic visit is to establish how the organisation addresses issues of clinical quality, patient safety and the patient experience, and the nurse executive's role in each.

- **Observational visits.** Three board observation visits, involving giving feedback to boards, or a subset of boards, on their discussions and processes, specifically in relation to clinical quality, patient safety and the patient experience, and the role of the nurse executive. However, all of this has to be considered in the context of how the board operates in general – not only in relation to clinical issues. This requires scrutiny of wider issues, such as the chair's style, the format of the agenda, and so on (see Appendix A for details of the observational headings). Our observations focused primarily on board meetings, but also included other meetings (for example, the clinical governance committee).

- **Coaching sessions.** Three telephone or face-to-face coaching sessions for each executive nurse, with the aim of boosting their impact and effectiveness at board meetings, in response to observations of their board in action.

- **Development grant.** Each of the nurse executives at the pilot sites is entitled to a £5,000 grant to use for their personal or professional development during the programme. This will relate to issues and learning objectives identified during the individual coaching and feedback sessions.

- **Nurse executive seminar.** A half-day meeting, bringing together the seven executive nurses to share best practice, establish a network and discuss emerging findings.

- **Presentation of findings.** A final discussion with the board or the executive, or individual members of the board/executive, to discuss the overall findings as they relate to their board.

The programme has drawn on two additional sources of information.

- **Literature review.** This examined the evidence on the extent to which nurse executives have made an impact in their organisations. The review included studies exploring the role and function of nurse executives, issues of pay, motivation and satisfaction, and involvement in commissioning.

- **Web-based exercise.** An internet-based exercise was carried out to enhance understanding of the role of nurse executives. This involved trawling the websites of a UK-wide sample of 26 NHS organisations for details of the portfolio carried by the nursing director. The sample comprised 12 foundation trusts, five NHS trusts, two PCTs, two mental health partnership NHS trusts, and two specialist NHS trusts, all in England. It included one NHS trust in Wales, one health and social care trust in Northern Ireland and one Scottish NHS board. The exercise identified 16 different job titles associated with the nursing director portfolio and a wide array of responsibilities, some more clearly defined than others.

The initial round of the programme involved recruiting seven pilot sites from across the UK. The sites included two foundation trusts, a partnership trust, and a PCT in England; in addition, one site each was recruited from Northern Ireland, Wales and Scotland. The pilot sites were chosen for the learning they could contribute about the role of the nurse executive in relation to high-quality, board-level clinical engagement, as well as management of patient care and the quality of the patient experience. The lessons learned from these pilot sites will be used to modify interventions for subsequent rounds of the programme.

The next phase of the programme, involving a further six sites, is already under way. The findings from this second round will be reported at the end of 2009.

Aims of this report

This report aims to disseminate the findings from the initial seven pilot sites, based on our observations of the structures, processes, relationships and other factors that support successful clinical engagement at board level.

The report is organised into seven sections, each highlighting the issues raised by a key question. The final section draws together emerging findings from the programme.

A note about terminology

A number of terms are used to capture what is meant by the 'business of caring'. The focus here is on the quality of clinical care, which is comprised of a number of elements, including patient safety, patient outcomes, clinical audit, clinical governance, the patient experience and patient satisfaction. We are interested in how an NHS board engages in total quality management, or continuous quality improvement. This includes having clear and long-term organisational goals around quality, ensuring that quality is the responsibility of all staff, and ensuring that the organisation focuses on learning from experience. Ultimately, it means being able to provide assurances that the quality of clinical care is at the heart of the organisation's business.

1 How does a board assure itself of the quality of clinical care?

Boards need to be able to assure themselves of the quality of clinical care in a manner that goes well beyond compliance with governance processes; assuring quality needs to be embedded across the whole organisation. Our observations have led us to focus on how boards do this. Two key questions are emerging:

- What information does a board need in order to assure itself?
- What is the role of the non-executive director in terms of assurance?

What information does a board need in order to assure itself?

Studies of NHS boards suggest that many are not reviewing sufficient information to assure themselves in respect of clinical governance (Dr Foster 2006; Corbett-Nolan and Malcolm 1999). Boards require a robust assurance framework, which enables timely and reliable clinical information to be brought to the board as a matter of routine. But exactly what information should be brought to the board to enable it to fulfil its assurance role?

There is a distinction between what boards *want* to know and what they *need* to know for assurance purposes. The nurse executives at the pilot sites regarded it as their responsibility to initiate discussion to determine what information their board considered valuable, and also to tell the board what it needed to know in order to stimulate thorough questioning. It remains unclear what information is needed.

Some of the nurse executives highlighted the need for a toolkit to provide a framework for the information needed by boards to assure clinical quality. A national focus on the patient experience, in the form of targets, was also mooted to ensure that clinical quality is mainstreamed and given equal status to areas such as finance. In many ways, the Darzi review delivers this – for example, with proposals for NHS boards to publish 'quality accounts' alongside financial accounts (Department of Health 2008). Such moves will force the balance of board agendas to change. The challenge will be to ensure that boards receive sufficient depth and breadth of information to provide assurances that a focus on clinical quality has permeated all aspects of the business.

Our observations provided insights into the inadequacies of some types of information that boards currently rely on (*see* Section 3). There are also issues about the quality and presentation of board papers, with some boards requiring members to wade through enormous piles of papers, which were not always clear to read, and sometimes at short notice.

Ensuring that sufficient time is given to interrogating information for assurance purposes can also be an issue. Researchers found that clinical issues and patient care formed a small proportion of board agenda items in 60 trusts examined, with just 14 per cent of items in board meetings directly concerning clinical issues (University of Plymouth 2006). Trust boards with a higher clinical content on the agenda shared two key features: a chief executive who linked clinical issues to all developments, and non-executives who questioned executives in an open manner.

The amount of time that boards at the pilot sites devoted to discussing clinical issues varied significantly. At one site, a quarter of the board meeting was scheduled for clinical matters. In contrast, the nurse executive at another site estimated that less than 5 per cent of agenda items concerned clinical issues, and concluded that the board: 'do not do an in-depth exploration of the patient experience'.

It is not just the percentage of time given over to assuring clinical quality that is relevant; it is also where clinical items are situated on the agenda, and whether they are presented for information or discussion. Where we observed clinical issues being dealt with at the end of a full agenda, when board members were very tired, it revealed a great deal about the priority given to quality (particularly as the chief executive of one such board had been resistant to calls from the nurse executive to move clinical quality higher up the agenda). There were other examples where boards appeared to move the reporting of clinical quality higher up the agenda as the programme progressed.

Boards in two of the pilot sites invited questions from public observers at the beginning of the meeting, which provided an opportunity for concerns about clinical issues to be raised for discussion early on in the meeting. We also observed sites where, although reporting structures around clinical quality were weak, there was at least a strong focus on quality and patient safety, with constant reference being made to both issues throughout board meetings.

What this highlights is that boards may genuinely value clinical quality, but there is a lot of uncertainty about how best to seek assurances in this respect. One site stood out for the approach it had taken to assuring clinical quality. During our observational visits, the board at this site was in the process of implementing a clinical quality strategy, owned by the medical director and based on the methodology developed by the Institute for Healthcare Improvement (IHI) in Cambridge, Massachusetts.

This aimed to embed clinical quality at all levels of the organisation. Clinical quality formed a separate board report at the meeting, and 25 per cent of the board agenda was given over to it (in practice, between two and three hours of discussion). The strategy provided a structure to identify clinical projects and set targets for achievement. Typical areas included slips, trips and falls, infection prevention, and acutely unwell patients. The strategy was accompanied by a patient experience strategy, led by the nurse executive, and a new 'quality' board that reported to the main board. The chair said of the strategy: 'It will help us get issues out in the open… but requires a culture change, which requires real board leadership.'

Another board we observed had established a strategic objective around quality, from which various targets flowed. These included establishing a patient safety programme board, developing a patient and public involvement strategy and setting the organisation a challenge in relation to dignity.

What is the role of the non-executive director in terms of assurance?

Non-executive directors need to work hard to assure themselves about quality. In order to carry accountability for clinical quality across the organisation, they need to have confidence that the right processes are in place and that the executive are operating these processes effectively.

Non-executive directors were described by nurse executives at the pilot sites as being increasingly 'hungry' for details about the patient experience. However, at some of the meetings we observed, non-executive directors were noticeably quiet, seldom challenging their executive colleagues, who were able to display that they were in control. At some

of the sites, the non-executives appeared to become more challenging, or at least more questioning, as the programme progressed. Where non-executives did not question the information they were given, it was difficult to tell whether this was because they felt fully assured of the quality of clinical care within the organisation, or whether there were other reasons.

The medical director at one site perceived a tendency for non-executives to limit themselves to 'safe' areas of questioning, for fear of appearing stupid. At another site, the medical director perceived non-executives to be more interested in issues of finance than quality. Where non-executives were observed challenging executives, their questions often centred on seeking clarification or further information. For example, one non-executive asked: 'Can we have a simplified map or idiots' guide to this document… I don't understand what has changed and what the impact will be on our services.'

Some of the non-executives who were more challenging of their executive colleagues sought explanations for a lack of progress, such as when one asked the following question in relation to cancelled operations: 'We seem to be moving further and further away from the target. Why can't we get on top of it?'

There were some examples of non-executive challenges that demonstrated the degree of probing non-executives really need to undertake to assure themselves of clinical quality. In response to a detailed presentation about a sudden, unexpected incident that had left the board visibly shaken, one non-executive director asked: 'Wouldn't you expect the ward manager to see and recognise the signs of a seriously deteriorating patient?'

The non-executives at this site were notable for the way in which they consistently asked powerful questions that cut to the nub of clinical quality. They frequently demanded better information in order to scrutinise the work of the executive and assure themselves that they were 'hearing the full story'. The executive responded to such requests with reporting procedures that tried to tell a large part of the story. We observed board meetings where every non-executive around the table contributed to every discussion. It was evident that the ability of non-executives to meaningfully question information was directly linked to the quality of the data they received. The non-executives at this site received information that enabled them to ask focused questions, including about trends and forecasts, and to continue to probe until the situation either improved, or they were satisfied with the answers given to them by executive colleagues.

It is unclear to what extent non-executives generally have the ability to sufficiently analyse issues, interrogate data and compare indicators, or indeed how well equipped boards are to support them in doing this. Our observations show that, where non-executives received good-quality data, they were more likely to be instrumental in making the links between different aspects of the business and clinical quality, and in specifying the type of data they needed in order to assure the quality of clinical care. In the absence of strong clinical reporting structures, non-executives should be asking questions about the clinical benefit and impact of the board papers they already receive.

Implications for development

- Nurse executives should play a part in stimulating discussion about what types of information boards want and need to know in order to assure themselves of the quality of clinical care.

- Boards should review the information they receive about clinical quality and the extent to which it provides the assurances they need. They should also give sufficient priority to this information within the meeting agenda. Papers need to be timely, focused and highlight the clinical impact.

- Boards should consider developing a dedicated strategy for clinical quality (possibly drawing on existing methodologies), or at least set strategic objectives.

- Non-executives need the skills to challenge colleagues, interrogate data, demand information where it is lacking, and focus on their assurance role.

- Non-executives are potential quality champions, and nurse executives should seek to help them develop their understanding of the processes and issues around the quality of clinical care.

2 What is the importance of context?

No two NHS boards are the same, partly because the context in which they operate will vary so considerably. This leads us to question the importance of context in relation to a board's ability to engage with the quality of clinical care. This section explores this issue in some detail and asks:

■ What contextual factors influence a board's engagement with clinical quality?
■ How important is the external environment?
■ What does it take to bring about change?

What contextual factors influence a board's engagement with clinical quality?

Both the length of time an NHS board has worked together as a corporate entity, and the degree of complexity it is required to deal with, have been found to influence its strategic leadership capability and commitment to the clinical governance agenda. Relevant factors in terms of complexity include the life stage of the board, its financial and clinical inheritance, the range and scope of clinical services provided, the demography of the community the organisation serves, and the wider health and social care economy of which it is a part (Stanton 2006).

The boards at the seven pilot sites were at different stages of maturity. One board was still dealing with post-merger issues during our observational visits, which explained a strong focus on productivity and achieving financial savings. Another trust underwent a merger midway through the programme. The members of this board, including a new chair and chief executive, were very much finding their feet and, again, achieving a stronger financial footing was a priority. A third site had completed a merger two years previously and, having achieved financial balance, was able to focus its attention on other pressing issues.

As might be expected, having a strong financial footing makes it easier for boards to ensure that finance does not dominate the agenda. Other benefits include greater potential to pursue initiatives related to clinical quality (such as around infection control and senior nursing staff provision), as well as better IT systems to support the clinical agenda.

In contrast to the boards that had undergone recent mergers, we observed the benefits that a period of stability can have. The board composition at one of the pilot sites had remained constant for a number of years, and this showed in the interactions between board members. This board had thought hard about how to embed clinical quality throughout the organisation and provided a good example of strong, strategically focused governance.

The behaviours that boards adopt to manage their context are dictated largely by the example and direction set by the chief executive and chair. The chief executive at a site on the cusp of a merger explained his management philosophy that clinical care and the

patient experience should sit at the heart of everything the trust did. This site had given attention to nurturing openness around incident reporting and had woven the patient experience into the culture of the organisation through a patient experience group and public involvement committee. The challenge for the nurse executive was to ensure that this culture was not lost in the merger.

How important is the external environment?

Achieving a strong focus on clinical quality is not easy, but at times we observed mere lip service being paid to the quality agenda – particularly where the board is under external political scrutiny. In some instances, the board claimed that it placed importance on the quality of clinical care but demonstrated very little in terms of action or focus. The challenge for the nurse executive is to build goodwill and capability to act positively.

Other external factors that can influence the ability of a board to engage with clinical quality include the onus to respond to national targets as well as to organisations that have an oversight function, such as Monitor (for foundation trusts) and the Healthcare Commission, which require a significant amount of data on clinical quality. Nurse executives at the pilot sites were undecided over the extent to which these system tensions could be useful in encouraging boards to discuss issues such as infection control that may otherwise have received little attention.

In the past, the NHS Confederation has identified a tendency for operational matters and national targets to dominate the boardroom agenda to the detriment of issues of strategy, quality and the patient experience (NHS Confederation 2005). Reflecting this, the nurse executives we spoke to believed that performance management and finance dominated boardroom agendas. This is despite the reality that failures in the fundamentals of care can bring down a board more quickly than failures in either finance or performance. Such emphasis has fostered a performance management culture, which nurse executives blamed for encouraging a sub-culture of macho leadership and, in some instances, bullying, which could seep into the boardroom. The external environment was thought to have created a climate of fear in the NHS that pervades boardrooms. Nurse executives perceived themselves to be the most vulnerable executives sitting around the table.

There have been some dramatic changes in the external environment, culminating in the Darzi review in England. This marks a decisive shift in emphasis on to the quality of care. In Scotland, there is a national focus on discussing issues such as dignity in the boardroom, and the expectation is that 60 per cent of the agenda should be focused on clinical issues. Whether the reality matches the rhetoric remains to be seen.

What does it take to bring about change?

A key issue in this study has been the extent to which context plays a part in creating an environment that is more conducive to improving clinical quality. Nurse executives at the pilot sites believed it often takes a crisis to disrupt entrenched practices and bring about change. In part, this was thought to be due to a sudden focus on resolving problems at the expense of stability and 'the way things are usually done around here'. The question as to which is more helpful – board stability or upheaval – remains a moot point, the former being increasingly difficult to secure in the constantly changing, volatile environment that is the NHS. Nurse executives also admitted to thriving in a crisis and to enjoying 'firefighting'. Paradoxically, there was a suggestion that they may even find it difficult to sustain momentum in terms of driving the quality agenda forward during periods of stability.

Where we observed boards with experience of serious clinical governance failings, these appeared to have kick-started serious consideration of clinical quality. One pilot site that had been under special measures was scrupulous about governance issues and, given past problems, mindful of the need to understand patients' experiences of care. However, we also observed how such organisations can be held back by anxiety over how much to discuss in public, given the negative attention they received around clinical failings.

To ensure that change does not happen only when there is a crisis, organisations need continuous learning systems that are open and transparent. However, nurse executives at the pilot sites were not confident of their organisation's ability to assure quality of care, principally because they felt the right indicators were lacking, and there was a culture where mistakes could not easily be discussed. Section 3 examines this theme in more detail.

Implications for development

- Boards should reflect on the environment in which they operate and identify the factors that hinder their ability to engage with clinical quality. Only by doing so can the board move towards addressing any imbalances.

- Boards need to ensure that they have continuous learning systems that are open and transparent.

3 What is the right clinical information?

The ability of boards to assure themselves in respect of the quality of clinical care relies on being able to scrutinise accurate and timely information. Yet there is a great deal of uncertainty around what types of clinical information boards need to receive. There are two key questions:

- What is the purpose of clinical information?
- What clinical information should be taken to the board?

What is the purpose of clinical information?

Data presented to boards may serve several purposes. These include:

- allowing board members to assure themselves of the quality of clinical care
- assisting decision-making
- providing snapshots of the patient experience
- airing recommendations for change
- engaging non-executive members and boosting their expertise and interest.

But over and above this, the way in which data on clinical quality and the patient experience is presented is central to their impact. Those presenting information to the board need to be clear about its purpose or there is a risk that the board will not engage with it. We observed a number of scenarios where data on clinical quality failed to capture the board's interest because the clinical impact of the data was not made explicit.

There would appear to be a number of challenges around the way that boards (and non-executive directors in particular) use data, and their ability to benchmark their performance against that of other health care organisations. There is a suggestion that data on clinical quality and the patient experience are often not relayed in a way that supports effective decision-making. 'We need a better way of telling patient stories to make decisions', remarked one medical director. There was a sense at some sites that non-executive directors either were not demanding enough information, or simply did not understand the clinical information they were given.

The nurse executive is well placed to take an authoritative lead in the boardroom to explain both the purpose of the data and what it illustrates. The nurse executive should be able to provide clinical advice to help colleagues interpret the data and make decisions based on it. So what factors can prevent nurse executives from doing this?

Some nurse executives at the pilot sites said that in order to present clinical information, they needed to know the board well enough to understand the best style to deliver data, particularly around the patient experience. This may be an area in which nurse executives need support. Much depends on relationships in the boardroom (*see* Section 4), the context in which the board is working (*see* Section 2), and the level of trust, honesty and open communication that has been allowed to develop.

A second challenge identified by nurse executives was how to enable boards to better understand data on improving the fundamentals of care (such as pressure injuries). Some nurse executives reported an expectation for them to limit their input to nursing issues rather than patient outcomes, which they themselves believed should be the focus for attention. Understanding how the organisation's data compare with data from similar organisations is a further challenge, especially given an increasing reluctance to share data because of commercial sensitivities.

The biggest challenge, however, is in deciding what is the right information to collect and when is the right time to present it. There was a lot of anxiety among nurse executives about what types of clinical information they should take to the board, but also a suggestion that a framework or portfolio of data could be developed to clarify this key area.

What clinical information should be taken to the board?

It was our intention to capture a key dataset, drawn from the range of information collected routinely across the seven pilot sites for presentation to their boards. However, the range and irregularity of information presented relating to clinical performance, quality and the patient experience made this task too complex. Instead, we have tried to provide examples of the types of data that would be useful at board level to initiate a different type of conversation.

Only one site had set aside agenda time to have a structured discussion about information strategies around clinical quality and the patient experience, as part of developing a new clinical quality strategy. At other sites, there was no evidence that such discussion had taken place, which may explain the wide variation we observed with regard to the amount and type of data, and the frequency with which they were reported. Some of this was related to the type of organisation. For example, primary care and partnership trusts devoted some attention to screening and community indicators that were not a focus for acute organisations.

Of the range of information presented, only the integrated performance report, which contains high-level performance indicators with little insight into underlying clinical issues, was used as the baseline for all the pilot sites. At sites where reporting systems for more detailed clinical information were weak, we observed a tendency to rely too heavily on the risk register and the integrated performance report.

Clinical dashboards or scorecards, which capture data in a colour-coded table format, were a better source of clinical information. Used properly, scorecards enable boards to see at a glance those clinical indicators where performance is below target and thus warrants attention. The nurse executive at one site had scorecard data, updated daily, on her computer, enabling her to take action quickly to resolve problems.

In addition to these sources of data, we observed boards discussing a range of other clinical information. At one site, a quarter of the agenda was given over to discussing clinical quality. This included a presentation on some aspect of clinical performance or a walk-about (to see the wards, for example), followed by presentation of the quality dashboard, then a report on particular aspects of clinical care (such as end-of-life care), a report on the clinical quality strategy, a report back from the clinical effectiveness committee, details of sudden untoward incidents, and patient outcome data (including patient surveys and complaints). Discussion of these data sources happened at the beginning of the meeting, reflecting the board's priorities.

The nurse executive at one site presented a monthly report, which effectively outlined the implications of nursing initiatives for patients in areas such as nutrition and hydration,

and dignity in care. This was complemented by an annual report with a strong focus on the patient experience, processes for improving quality, clinical audit, patient safety and clinical risk, incidents, patient falls, and infection prevention and control.

At another site, a bi-annual report by the nurse executive used the *Essence of Care* benchmarks (NHS Modernisation Agency 2003) as a framework to report on patient care, patient safety and clinical quality. A priority at this site was to examine existing data in a more sophisticated way in order to develop the organisation's own targets. Consequently, the nurse executive's report had been replaced by a quarterly report on the patient experience (not led by the nurse executive), which was based on patients' feedback and set out the actions the organisation was taking in response. Another site had introduced a report on the patient experience, which limited attention to one or two clinical areas each month, such as slips, trips and falls.

The nurse executive at another site was piloting her own clinical indicators and had begun reporting annually on patients' perceptions of things like hand-washing, cleanliness, the provision of information, involvement in decision-making, respect and dignity, privacy, and help with eating. Using patient-reported outcomes in this way can enable boards to engage better with the patient experience. This was particularly important for the board at this site, which had just one clinical item on its agenda at the time of our observation visit.

'Soft intelligence', in the form of patients' own stories, is another way to highlight clinical issues that routine, hard data fail to capture. Our observations suggest that a combination of hard, quantitative data and softer intelligence such as personal stories best enables boards to fully engage with the patient experience. Where boards received only quantitative data, and where patient stories and other key clinical indicators were reported to other structures such as the clinical governance committee, the board had a less rounded picture.

Other techniques strengthened the information that was presented to the board – for example, nurse executives providing a great deal of narrative to help interpret and bring to life hard data. The involvement of other clinicians in the presentation of data also helped.
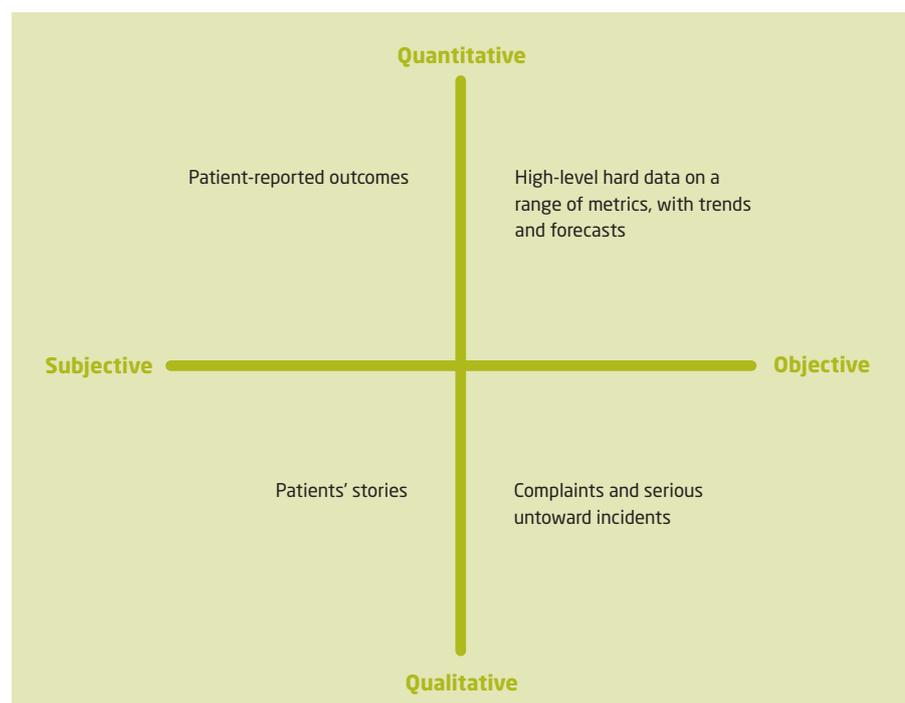
Overall, our observations suggest that ensuring boards get the right clinical information is about obtaining a balance between the types of information presented to them. A really mature board will be able to operate against all four of the quadrants we have identified (*see* p 19).

Implications for skills development

Based on our observations at the pilot sites, we have identified five principles that underpin good information on clinical quality. These are:

- quantitative data, including metrics and trends, with narrative that interprets the data and draws on 'soft intelligence' such as patients' stories

- succinct presentations that focus on one area, issue or service at a time

- consistency in presentation and format of clinical information

- a transparent process for indentifying new priorities

- a regular, protected slot on the agenda, which allows sufficient time for discussion.

Nurse executives need the skills to be able to analyse, interpret and present quantitative data, and also to present narrative about the patient experience that adds a more personal dimension to care.

4 What are the key relationships in the boardroom?

Boardroom dynamics can be notoriously complicated. We observed a range of different behaviours and interactions among executives, and between executives and non-executives, during the first phase of the programme. Our interest in the conditions that are most likely to support strong board-level engagement in clinical quality led us to identify three key questions:

- What are the key alliances?
- What relationship should executives and non-executives have?
- What are the key relationships for the nurse executive outside the boardroom?

What are the key alliances?

The quality of leadership by the two top figures – the chair and chief executive – has a strong correlation with the overall success of an NHS organisation (NHS Appointments Commission 2003). The relationship between these two is also relevant to board engagement with clinical issues. At one site, we observed the benefits of a close working relationship between the chair and chief executive, who had complementary styles, and shared an interest in clinical quality. The chair's commitment to clinical quality was evident in the way she personally delivered training on clinical engagement to new non-executive directors. The nurse executive at this site said: 'I don't meet any resistance to putting quality on the same footing as finance.'

Conversely, a chair who is trying to expand opportunities for discussion of clinical issues will struggle where the chief executive is uninterested and can exert significant control over the agenda (just as dominance the other way can also skew discussion).

At one of the pilot sites, the nurse executive was observed working closely with both the chief executive and chair to champion aspects of clinical quality at board level. This nurse executive commanded considerable authority and was clearly regarded as a respected and valued member of the leadership team. More often, the key alliance for nurse executives was with the chief executive only. This is hardly surprising, as the nurse executive reports to the chief executive. The different values, leadership and management style of chief executives has been found to have a major impact on how nurse executives feel about their jobs and carry out their work (Girvin 1998).

We observed a variety of boardroom behaviours by chief executives, which undoubtedly influenced the executive team. These ranged from linking every agenda item to clinical quality, to appearing heavily focused on achieving financial targets, and from not having a strong presence, to appearing uninterested in responding to questions from non-executive directors (which had the effect of silencing the executive team).

Our observations suggested that nurse executives who enjoyed good support from their chief executive were able to be more confident and more commanding of respect. This in turn enabled them to be more courageous and transparent in terms of the information they brought to the board. Where support from the chief executive was perceived to be

lacking, the nurse executive was more likely to struggle to assert his or her presence in relation to clinical leadership and clinical engagement. Nurse executives without clear support were also more likely to feel a need to balance negative information with positive, and to hold back information that could undermine their position (*see* Section 7 for further discussion about when to present boards with bad news).

The changing external environment, culminating in the Darzi report, means that focusing on clinical quality is no longer optional. Nurse executives at the pilot sites identified a number of strategies aimed at tackling situations where the chief executive was perceived as having a lack of interest in clinical quality. These included: engaging the whole board rather than just the chief executive; engaging the chief executive on clinical issues outside of the boardroom; and harnessing the rest of the executive team to influence the chief executive.

This highlights the importance of moving out of executive silos and developing alliances behind the scenes to support discussions within the boardroom. Key allies for nurse executives include the director of performance and non-executive directors, but nurse executives at the pilot sites also highlighted a need to create alliances beyond their immediate sphere, to include human resources and finance, for instance.

NHS organisations would seem to be better placed to focus on clinical quality where both the medical director and nurse executive have joint presence and authority as senior clinicians. From our observations, despite the good relationships between the medical and nursing directors, there was little evidence of joint working between these two at the board. For example, at one site, the nurse executive presented a paper on infection control without any input from the medical director, which risked limiting the issue to one about nursing, rather than an issue for all the clinical professions. One site was notable for the collaborative relationship between the nurse executive and medical director, who often shared responsibility for bringing quality issues to the attention of the board.

Where nurse executives and medical directors work together in this way, there are a number of advantages: shared responsibility for what can be a challenging agenda, peer support, a cohesive clinical voice at the board table and, consequently, greater impact in the boardroom. It also role-models a new and different dynamic for how doctors and nurses can work together, which challenges historical hierarchies. Such role-modelling may help to increase clinician engagement at board meetings. The presence of more clinical staff at board meetings is associated with boards with a higher clinical content on the agenda (University of Plymouth 2006). The Scottish model has many more people with a clinical background around the board table, including representatives from public health, pharmacy and dentistry.

What relationship should executives and non-executives have?

NHS boards need executive and non-executive directors with a range of complementary skills, and who strike the right balance between operating as a team and avoiding deferring to the collective view without expressing their individual opinions (Department of Health 2006b). Successful boards ultimately depend on the level of constructive challenge between executives and non-executives, and among executives.

A lack of executive-to-executive challenge has long been identified as an issue for many NHS boards (NHS Confederation 2005). We observed that executive-to-executive challenge tended to be weak across the seven pilot sites. The nurse executives were often observed being supportive of executive colleagues, when they could have been more challenging.

The role of non-executive directors in challenging executives was examined in Section 1. The degree to which non-executives challenge their executive colleagues, and the manner in which they do so, can present tensions in the boardroom, tensions that have ramifications for discussions around quality. At one site where we observed the level of scrutiny by non-executives to be particularly strong, the executive largely refrained from engaging in debate. The executive team had already discussed the board papers in a pre-meeting with the chief executive, from which the non-executives were excluded. There was a danger of a 'them and us' dynamic developing, which might cause the executive to be defensive.

While it may be necessary for executive meetings to be held in advance of the board meeting to discuss the papers to be presented, it is important that this is not at the expense of the relationship between the executive and non-executive. Executives and non-executives need to develop openness, trust and a sense of shared purpose. This is particularly important for facilitating difficult discussions around patient experiences that may not show the organisation in a good light.

What are the key relationships for the nurse executive outside the boardroom?

One nurse executive summarised her role as being to ensure that good clinical governance was in place, but without doing everything herself. She saw her role as working with her executive colleagues to engage them so that they would think about clinical governance in all areas they were accountable for. Hence, influencing the other directors (directors of finance, operations, performance and human resources) so that they could account for the impact of their decisions on the patient experience was a key part of her role. Her ability to do this effectively strengthened her presence as part of the executive team. Other nurse executives felt strongly that it was their responsibility to 'manage' their boss, the chief executive, and this meant finding opportunities to educate them about the patient experience and expose them to the patient care agenda.

Nurse executives who find themselves somewhat isolated in the boardroom in terms of executive clinician support may wish to consider seeking support outside of the organisation. Despite significant variations in their role and the contexts in which they operate, it was clear from the pilot sites that nurse executives within different organisations share similar challenges. There is real potential for nurse executives to seek strength and support from each other. This was a strong theme to emerge from the seminar held for the seven pilot site nurse executives.

One way to facilitate this is for nurse executives within strategic health authorities (SHAs) to develop networks for those in similar roles, working in different types of units. Only two nurse executives in the pilot sites referred to having contact with their SHA chief nurse. Their comments suggested that this relationship holds far greater potential than is currently realised, with one nurse executive describing the SHA counterpart as 'very hands-off' and the other, from a non-acute unit, maintaining that the SHA nurse executive was very focused on acute care.

Implications for skills development

- Chairs and chief executives need to work closely to reinforce the importance of clinical quality at board level.

- Chief executives need to reflect the importance of clinical quality to the business in all their interactions at board meetings.

- Nurse executives need to work to secure the support of their chief executive in driving the quality agenda, including engaging the chief executive on clinical issues outside of the boardroom, harnessing other members of the executive team to influence the chief executive, and engaging the whole board in quality issues.

- Nurse executives should give attention to building alliances with executive colleagues outside of the boardroom.

- Nurse executives and medical directors should exert their authority as executive clinicians by developing collaborative relationships that support joint working.

- All members of the board should place value on constructive challenge as part of the process of assurance about clinical quality.

- Nurse executives should exploit any opportunities for peer support and networking with nurse executives from other organisations.

5 What is the right balance between effective board relationships and robust governance structures?

One of the issues that has emerged from the pilot site observations is whether relationships (explored in Section 4) or structures and processes are more important in terms of bringing the ward to the board. This section highlights three questions that cut to the core of this issue:

- Who should be responsible for driving the quality agenda?
- To what extent do boards delegate clinical engagement?
- Can a strong nurse executive compensate for weak structures?

Who should be responsible for driving the quality agenda?

The most effective boards have been identified as those where all the directors contribute and do not restrict their input to their particular specialty or interest (NHS Appointments Commission 2003). If just one member of the executive shoulders responsibility for clinical quality, this risks marginalising the quality agenda, which – given that it cuts to the heart of the business of caring – should be an issue for the whole board. The new emphasis on quality heralded by the Darzi review makes shared responsibility essential.

It is logical that executive directors with a clinical background should play a prominent role in bringing issues of clinical quality to the board. But this does not mean that they should be regarded as sole custodians of clinical quality. Indeed, too much emphasis on the role of the nurse executive or medical director in driving clinical quality at board level could result in the credibility of the quality agenda resting on the credibility of the executive clinician. This is a particular issue for the nurse executive, given the status traditionally awarded to nursing roles. Making the nurse executive the champion for clinical quality may, perversely, serve to downgrade the importance of the quality agenda (*see* Section 6 for further discussion of this issue).

The nurse executives at the pilot sites identified a need to share responsibility and accountability for clinical issues at board level. For the nurse executive, it means letting go of a belief that they can and should hold everything together (*see* Section 6). It also means being clear about the distinction between influencing colleagues to ensure that clinical quality is at the forefront of all aspects of the business, and taking accountability for the quality of clinical care (*see* Section 4).

The real potential of the nurse executive role would appear to be in spelling out the relevance of clinical quality for the business, helping to create the right culture and climate to have open discussions about quality, and leading by example by constantly reinforcing the importance of clinical quality to all aspects of the business.

The ability of the nurse executive to share responsibility for clinical quality is heavily influenced by how the board goes about assuring itself in this respect. This is where the balance between relationships and structures becomes complicated, particularly as the

pilot site observations suggest that what goes on in the boardroom may tell only half the story.

To what extent do boards delegate clinical engagement?

The degree to which boards delegate their clinical engagement function, and how they do so, is difficult to map when observing NHS organisations. Delegation happens not only to formal structures such as governance committees, but also to informal structures, such as non-executive director briefings and board seminars. Delegation therefore tends to be complex, inaccessible and, to the external observer, somewhat confusing. Some informal discussions about clinical quality issues can be helpful, but they should not replace a discussion of clinical quality formally at the board.

Almost all of the boards at the pilot sites relied heavily on sub-committees – principally the clinical governance committee or equivalent – to provide assurance in relation to clinical quality. The board meeting at one site appeared little more than a rubber-stamping exercise; there was very little detailed discussion on any aspect of clinical quality, because quality issues were covered by various sub-committees, which meant that debate happened elsewhere. The chair of another board admitted to a reluctance to allow much challenging debate at the meeting, instead preferring that debate be conducted in other settings.

One pilot site was notable for not delegating too much on sub-committees, in the belief that clinical governance mechanisms were bureaucratic and could divert attention away from pertinent issues. Yet where we had the opportunity to observe a clinical governance meeting, we witnessed a good-quality discussion, combined with a higher level of executive engagement than during the board meetings (possibly because the meeting was less formal and non-executives were not present). The real issue is whether delegation to sub-committees and other structures enables the board to sufficiently assure itself in relation to the quality of clinical care.

Much depends on having effective and clear flows of information between the delegated structures and the board. One board discussion we observed centred around whether it was necessary to have a non-executive sitting on the clinical effectiveness committee. It was decided that this was unnecessary, as the board devoted a quarter of its agenda to clinical issues, in addition to regular risk reporting by the medical director. For other boards, it may be enough to know that the organisation undertakes rigorous audit and that learning and improvements are made on the back of this. At another site, the non-executive directors were assured of clinical governance by having a non-executive director chairing the clinical governance committee.

What is unclear is whether board assurance processes can ever be sufficient where clinical quality is not a feature of mainstream reporting at board level. Where the board lacks formal processes to assure itself of the patient experience of clinical care, does this place greater reliance on the nurse executive to fill the gap?

Can a strong nurse executive compensate for weak structures?

The importance of the nurse executive's relationship with the chief executive, and the extent to which this equips them with confidence and authority in the boardroom, has already been highlighted (*see* Section 4). The question is, what happens when there are effective relationships but the structures, systems and processes are weak?

Where we observed a strong nurse executive working within weak reporting structures, the nurse executive had to work hard to convince the (newly established) board of the

value of engagement in clinical quality. More often, where we observed an authoritative nurse executive, the board was usually characterised by robust reporting processes around clinical quality, or at least a strong focus on the issues. It is unclear which came first: the influential nurse executive or the robust structures and processes.

What happens when the situation is reversed? Can strong structures and processes support a weak or inexperienced nurse executive? In one site we observed, the nurse executive appeared not to have asserted her presence in a powerful boardroom, but the chair and chief executive then created space for clinical quality to be brought into the boardroom by inviting the nurse executive to develop a bi-annual report for the board. Without their support, this nurse executive was unlikely to achieve the type of cultural shift that was required.

Where engagement in clinical quality has been delegated to another level, the nurse executive needs to exert a strong influence outside of the boardroom. If nurse executives are not fully involved in the structures that clinical quality is being delegated to, they risk losing their impact at board level. We observed one board meeting where the nurse executive was unable to talk about a clinical effectiveness report because she had not attended the clinical risk committee that dealt with it.

Implications for skills development

- Boards should be explicit about making the quality of clinical care an issue for the whole board. Developing a strategic objective around quality could help with this.

- Boards should consider the extent to which they delegate clinical engagement to other structures, and whether this supports or inhibits the board's ability to assure itself in respect of the quality of clinical care.

- Boards need to examine whether they create the right environment to facilitate relationships that support engagement in clinical quality.

- Nurse executives need to resist shouldering sole responsibility and accountability for clinical quality and instead focus on spelling out its relevance for the whole of the business.

6 What difference can the nurse executive make?

Our observations and discussions with nurse executives at the seven pilot sites suggest that there is a lack of understanding about the power and potential of the nurse executive role. In many ways, the role is individually driven and defined. The nurse executive's impact at board level therefore depends on the individual's values, commitment and aptitudes.

In considering what difference the nurse executive can make in driving clinical quality at board level, a number of questions have emerged:

- What value does the board place on the nurse executive role?
- What capabilities should a nurse executive have?
- What role does the board have in developing the nurse executive?
- How does the nurse executive bring the ward to the board?

What value does the board place on the nurse executive role?

Nurse executives represent nursing systems and nursing at the trusts in which they are employed. Their nursing background provides a unique oversight of the quality of clinical care. Yet some of the nurse executives at the pilot sites believed that they were defined primarily by their nursing background and that this resulted in them being sidelined and given less weight in the boardroom than, for example, their finance colleagues.

There is evidence that the nurse executives at the pilot sites were not alone in feeling this way. A survey of 200 nursing directors found that 70 per cent of them believed that a barrier to becoming chief executive was because, as nurses, they were stigmatised. The perception of nursing as a subordinate, submissive profession was believed to pervade the NHS, including at board level (Faugier and Woolnough 2001 p 39).

Nurse executives at the pilot sites saw themselves as an easy target for blame, and described their role as 'dispensable' and 'easy to get rid of'. This was supported by the belief that nurse executives can become containers for organisational anxiety, a phenomenon first described by Isabel Menzies (Menzies 1960), a psychoanalyst at the Tavistock Clinic, and that their presence in the boardroom can be an uncomfortable reminder of problems with patient care. It is compounded by a tendency for the nurse executive to be regarded as a 'doer' and a 'fixer'. The nurse executive at one of the pilot sites remarked that whenever she raised the patient experience in the boardroom, she often picked up all the actions associated with that discussion.

The nurse executives at the pilot sites believed that a tendency to take personal responsibility for problems came from their core value of caring. One nurse executive commented: 'You're trained as a nurse to care for others. You can't park that as a nurse executive.' This can lead to difficulties for nurse executives in sharing responsibility for clinical engagement at board level. Other effects include isolating nurse executives from colleagues, causing professional rivalry, and putting their own position at risk. The

pressure this can create was summed up by the comments of one nurse executive: 'What if I don't get it right and the organisation fails?'

This perceived vulnerability could lead to some defensive practices, which could in turn compromise the information that nurse executives present to the board. Those nurse executives who were uncertain of their value at board level were more likely to feel a need to balance negative information with positive, and to hold back information that could undermine their position. These nurse executives spoke of a need to 'spin' information – of 'saving your skin' rather than proactively considering the board's wants and needs.

A sense of holding a subordinate position in the boardroom is more likely to be an issue where nurse executives limit their contributions to clinical issues. Nurse executives at the pilot sites who were observed as having a significant impact in the boardroom were able to talk convincingly about the business of the whole trust, and how clinical quality fitted into this strategically.

Our observations suggest that nurse executives need to speak with an equal voice on corporate issues in order to grasp authority and avoid being sidelined on clinical issues. Establishing their presence across the breadth of discussions helps to ensure that, when they do raise clinical issues, they are not downgraded or dealt with in a marginalised way. The nurse executives at three of the pilot sites limited their contributions to clinical issues at early board observations, but after coaching sessions and feedback based on observation, they demonstrated a more comprehensive grip on issues at subsequent board meetings and their impact and authority was visibly greater.

One recurring theme from our observations at the pilot sites, and also from the literature (*see*, for example, Rabjohns 2007), is the need for nurse executives to become more financially and commercially astute in order to thrive in increasingly business-oriented boardrooms. Such skills should enable nurse executives to contribute to the whole business of the board and increase their overall impact in the boardroom. Yet there is a delicate balance to be struck.

Where the language of the board is very business-oriented and focused on metrics, our observations suggest that nurse executives need to guard against adopting this style, and instead retain their own approach at the board table, and specifically, their focus on caring and the patient experience. For example, one nurse executive we observed relied on the language of performance management to respond to a question about negative patient experiences. This was received badly by the non-executive directors, who it seemed wanted a more emotional or compassionate response that reflected commitment and care. The challenge for nurse executives is to develop their own style and deploy it in a confident way, which draws on a wide range of business skills and yet does not lose sight of the essence of their invaluable role.

What capabilities should a nurse executive have?

The effectiveness and credibility of the nurse executive is also heavily dependent on his or her ability to demonstrate a range of capabilities. Nurse executives at the pilot sites identified the following as key:

- synergy with the political agenda
- an ability to unite staff
- personal drive, presence and authority
- being able to articulate the contribution of nursing to the organisation
- finding time for strategic thinking
- developing intelligence – keeping in touch with what is going on.

Our observations of boardrooms identified additional competencies specifically related to the ability of the nurse executive to encourage the board's engagement with clinical quality issues. Nurse executives need to be able to demonstrate:

- enthusiasm for the role
- an ability to manage a demanding and complex workload, while being clear about the nursing element of the role
- an ability to deploy their knowledge, skills and experience as clinicians
- an ability to communicate persuasively in order to raise the profile of clinical quality at board level and across the organisation
- an ability to discuss clinical issues with credibility and confidence and help the board understand the quality agenda
- intellectual flexibility, including an ability to respond to a wide range of questions, from carpets and costs to patient outcomes and hygiene
- an ability to effectively balance operational issues with strategic ones
- confidence, to contribute to discussions on a wide range of corporate issues (such as finance) as well as clinical issues
- business skills/commercial acumen/finance skills
- an ability to manipulate and analyse both quantitative and qualitative data and present it with impact
- emotional intelligence – an ability to convey the emotional content of the patient experience with compassion, yet without becoming emotional.

The importance of personal style cannot be overplayed. Where nurse executives were observed as having presence in the boardroom, their tone, style and body language reflected authority, confidence, competence and credibility. This was another area in which the coaching sessions with individual nurse executives proved to be a useful intervention.

What role does the board have in developing the nurse executive?

The ability of the nurse executive to bring quality issues to the board can be undermined by the complexity and scope of what is usually an extremely demanding portfolio of work. Tensions are most likely to exist over the balance between strategic and operational responsibilities. This can affect the ability of the nurse executive to develop strategic focus, including reflecting upon and developing their own role. Uncertainty over where nurse executives should focus their energies can be compounded by uncertainty on the part of some boards in terms of their expectations of the executive clinical function.

Involvement with this programme helped some of the pilot sites to initiate discussions about the role and responsibilities of the nurse executive. For example, at the beginning of the programme, the nurse executive at one pilot site remarked: 'I am pushing faster as the operations director than I am as the nurse executive and I know I could do the professional role better.' By the end of phase one of the programme, this nurse executive had relinquished operational responsibilities to develop a more strategic, professional nursing role, with a view to supporting a move to a chief executive post in the future.

Aside from this example, the trust boards at the pilot sites were generally not explicit about their role in managing the capabilities of their nurse executive or indeed their expectations of this role. Based on our observations, there would appear to be little consistency in the support provided to nurse executives and the resources directly available to them. This may reflect the fact that NHS boards have traditionally given little attention to their own development. Where reviews of board performance have

been undertaken, performance evaluations have rarely included an assessment of the executives' contributions (Bevington *et al* 2005).

How does the nurse executive bring the ward to the board?

One of the most valuable aspects of the nurse executive role is the potential to serve as a conduit of information about the realities of the patient journey and, by doing so, to bring the ward to the board. Where we observed nurse executives successfully bringing the patient experience to the attention of the board, this was in part attributable to their use of 'soft intelligence'. Presence on the shop floor and nurturing relationships with nursing staff in wards and departments were key elements of this.

> Together with her senior nursing colleagues, the nurse executive at one pilot site returns to uniform and works with patients for one day each week. Part of the day is dedicated to a weekly clinical indicators meeting, which provides an opportunity to identify problems quickly and bring serious concerns to the attention of the board far more speedily than would otherwise be the case. Sites such as this placed real value on using different sources of information, including staff perceptions and patient experiences, to find out about clinical quality.

Nurse executives at the pilot sites believed that engaging with the patient experience may require boards to shift the focus away from the monthly meeting – which risks becoming an end in itself – to spending time on the shop floor. Where the chief executive, chair and non-executive directors spent time on the shop floor, it enabled them to keep an ear to the ground in terms of clinical quality and also reinforced a sense of shared responsibility.

Nurse executives at the pilot sites who did not maintain regular ward-level contact or undertake any clinical work appeared disadvantaged in terms of being able to explore issues of clinical quality proactively. Similarly, nurse executives who relied on deputies to provide assurances about clinical quality through staff and patient contact risked being isolated from the patient experience, only ever gaining third-party insight. Too much delegation of this kind could undermine the clinical credibility of the nurse executive. This was evident at one of the pilot sites, where we observed both the nurse executive and medical director inviting others to speak to the clinical agenda on their behalf.

Nurse executives need to be able to tell a good story in order to bring the reality of the wards into the boardroom. The use of narrative to capture the patient experience can be a powerful way to integrate clinical quality with other aspects of board business. For example, we observed the nurse executive at one site convey in a very honest and rich way the activity at ward level and its implications for the business at a strategic level. Narrative around the patient experience can also help colleagues to understand the reality behind quantitative data and its impact. Section 7 looks at some of the challenges inherent in discussing the patient experience.

Implications for skills development

- Boards need to articulate the value they place on the nurse executive role and their expectations for what it can deliver.

- Nurse executives need to be able to talk convincingly about the business of the whole trust, not just clinical issues.

- Nurse executives need to be able to draw upon a wide range of capabilities. They also need to reflect on how their demeanour, tone and level of confidence affects their impact in the boardroom.

- Nurse executives need dedicated time to plan and prepare for their contributions at board meetings.

- Nurse executives should initiate discussions with their chief executive officer about their career development as part of an ongoing dialogue about their role and responsibilities.

- Boards may wish to consider a more flexible approach to meetings, including spending time on the shop floor to better understand the patient experience.

7 When are board members ready to hear bad news?

It is important for all NHS boards to assure themselves that their organisation understands outcomes from a patient perspective, and what these say about the quality of care. For organisations that have experienced problems around clinical quality or been under special measures, this awareness is even more crucial. Yet our observations suggest that, too often, boards shy away from discussing patient experiences that reflect negatively on the organisation. This gives rise to three key questions:

- How does bad news reach the board?
- How important is it to create the right climate?
- What role should the nurse executive play?

How does bad news reach the board?

Based on our observations, it would seem that there is often a reluctance to allow negative feedback into the boardroom. Complaints can be an important source of clinical information; yet the substance of complaints was rarely discussed, and instead the focus was limited to numbers and response times. One site highlighted the learning that can be gained from dealing with complaints, producing an annual report that highlighted changes to practice taken as a result of complaints about services.

Similarly, during our board observations, patient safety incidents were generally dealt with in a very cursory way, often focusing on issues of liability and corporate risk. Not only was an opportunity for clinical learning lost, but the board invariably missed a chance to have a caring conversation and to express humility in relation to such incidents.

Where patient safety incidents were given a more in-depth treatment, the board recognised the importance of acknowledging the emotional component of these issues, and had sufficient opportunity to interrogate data and assurance processes. Boards may well argue that complaints and patient incidents are discussed in other forums, such as the clinical governance committee, but it is questionable whether the board can, and should, delegate dealing with reports on the patient experience and the emotions that accompany them. It also raises issues about openness and public scrutiny.

The degree of openness and transparency at board level has been found to have a direct relationship to clinical quality (University of Plymouth 2006). There are two components to this: openness of the board in public; and openness and trust within the top team in private. A tightly bonded team in private can paradoxically serve to limit public scrutiny in tightly rehearsed and controlled board meetings, where nothing is allowed to surface that could cause embarrassment.

We observed a tendency for boards to use 'part two' of meetings (held in private) to discuss 'difficult' issues – issues they were not prepared to discuss in public – such as patient deaths. The patient experience may also be discussed informally among executive colleagues, without the involvement of non-executives. Not only does this raise issues of public accountability, it also limits opportunities for learning between boards. (This is

compounded by the increase in foundation trusts, which has created a tendency to limit access to board papers, and particularly to them being made available on the internet.)

The link between openness and creating a learning organisation, in which mistakes can be openly discussed and lessons learned, is well documented. Closing down opportunities for discussion in public about difficult patient experiences ultimately undermines the ability of the board to reassure external audiences that it is a learning organisation, focused on clinical quality. For example, two of the pilot sites demonstrated their openness to public scrutiny by inviting questions from the public at the beginning of the board meeting. At one meeting, a member of the public made an emotional speech about MRSA at a local hospital. This provided the board with an opportunity to give assurances publicly in relation to this issue.

There were other examples where boards willingly accepted contributions from the public, or dedicated time in advance of the board meeting to hear views from the public. However, some boards did not invite comments or questions from the public and appeared half-hearted in their attempts to involve the public – for example, allowing members of the public to observe board meetings but failing to make sufficient papers available for those who attended. One site held all board meetings entirely in private.

How important is it to create the right climate?

We observed that board members were often at their most engaged and energetic when discussing patients' experiences of care. However, such discussions can be uncomfortable for non-executive directors, particularly where they involve hearing about the distress caused to patients and their families, or about events that reflect badly on the organisation. There is a need for non-executive directors in particular to respond appropriately and proportionately to negative feedback about the organisation.

The chair's direction and the tone he or she sets for the board meeting is of fundamental importance. The chair at one site was observed treating the board sensitively and acknowledging difficult and uncomfortable issues. This chair created a climate of honesty, tackled difficult questions and resisted moving on to other issues too quickly.

In contrast, the way in which chairs at other sites managed meetings inhibited discussion about patient experiences of the quality of care. At one site, the board appeared uninterested in hearing about the patient experience and engaged in little discussion of any kind; the chair at this site fostered a 'no surprises' culture and was anxious to avoid embarrassment. The non-executive directors at another site complained that their discussions were too sanitised because they were too tightly managed by the chair.

What role should the nurse executive play?

Even the most confident and experienced nurse executive can find it difficult to relate stories about the patient experience that do not show the organisation in a good light. Indeed, one of the main challenges nurse executives at the pilot sites perceived was in raising the profile of clinical engagement without alienating colleagues with bad news. This was underpinned by a belief that some boards were simply not ready to receive negative data ('data for improvement'). Nurse executives expressed anxiety about the reaction negative patient stories would receive within the boardroom and a real or perceived concern that the responses from non-executive directors and other external representatives, such as governors, would be difficult to handle.

The challenge for the nurse executive is to raise difficult clinical issues with credibility and confidence, and that means developing emotional intelligence: tapping into the emotional

content of the patient experience without becoming emotional. Emotional presentations risk undermining the credibility of the nurse executive, as well as losing the engagement of the chief executive and others around the table. This is likely to be a particular issue for those working in a high-performance culture and a boardroom dominated by a focus on metrics and hard data. At one site, it was the nurse executive who was observed inappropriately relying on business language to answer a question from non-executives that required the emotion of the situation to be communicated.

One nurse executive told us about her plans to help make the board more open to emotion. This nurse executive perceived her own role as demonstrating the right kind of behaviours that allow emotion to enter the discussion, and resisting a temptation to react defensively to criticism. However, she was anxious not to risk losing credibility and highlighted the challenge of developing emotional intelligence in the boardroom in the presence of non-board members or with the public or press in attendance.

Such comments reveal the importance of trust between board members who act cohesively. Nurse executives at the pilot sites who successfully articulated the patient experience attributed this to the board's openness to receiving such information. The nurse executive at one pilot site said: 'I have confidence in the board's willingness to hear my stories.' Another remarked that she 'feels safe' on the board. This is in contrast to the nurse executive at another site, who was asked by the chair to remove mention in a paper to go before the board of a complaint that had been poorly managed.

A shared language in the way that patient experiences are reported, which acknowledges the emotional content of this type of data, could also have benefits. The *Essence of Care* toolkit (NHS Modernisation Agency 2003) may be helpful here. It provides benchmarks in eight inter-related areas of care, including personal and oral hygiene, food and nutrition, pressure ulcers, and privacy and dignity. Such benchmarks could help boards to take a patient-focused and structured approach to comparing practice and improving the patient experience.

Implications for skills development

- Boards need to consider how they assure themselves that they understand the patient experience and the implications for clinical quality. This means discussing the substance as well as the number of complaints and patient safety incidents.

- Boards need to consider how they demonstrate openness to public scrutiny.

- Chairs need to focus on creating a climate in which patient stories can be discussed frankly, which includes acknowledging the discomfort such discussions may cause.

- Nurse executives need to develop emotional intelligence in order to discuss difficult clinical issues with credibility and confidence.

- Nurse executives need to consider the language used to present the patient experience and to avoid use of business-oriented metrics that fail to accommodate the emotional content of patient stories.

- Nurse executives need to role-model appropriate behaviours around presenting and receiving bad news.

- Non-executive directors may need training and other support to help them react appropriately and proportionately to patient stories.

8 Emerging lessons for the programme

Lessons learned about clinical engagement by NHS boards

Based on our observations at the seven pilot sites, the following factors are emerging as important in enabling boards to engage effectively in clinical quality.

- **Having the right building blocks in place,** specifically: the right information; recognition of the importance of relationships and robust governance arrangements; and strong clinical leadership and clinician engagement.

- **Enabling boards to embed assurance of clinical quality across the organisation.** This relies on having the right processes in place and the right relationships for continuous quality improvement.

- **Having a strong financial footing and a readiness to respond to the changing external environment.**

- **The availability of certain types of information, which can help to kick-start a conversation about clinical quality at board level.** Effective boards give information on clinical quality high priority on the agenda and allow sufficient time for debate.

- **Chairs and chief executives who work together to reinforce the importance of clinical quality.** The lead given by the chair and chief executive dictates how boards prioritise and treat the clinical quality agenda.

- **Making it explicit that clinical quality is an issue for the whole board.** This may include developing a clinical quality strategy or strategic objectives.

- **Where boards rely on other structures (such as sub-committees) to provide assurances about clinical quality, there are clear and effective flows of information from these to the board.**

- **Demonstrating the learning environment by valuing and acting on intelligence on the patient experience, including complaints and incidents.**

- **Demonstrating openness and transparency to public scrutiny at board meetings.**

- **The role of the chair in creating a climate and culture in which the patient experience can be discussed openly, and which acknowledges any discomfort such discussions may cause the organisation.**

- **Non-executive directors who constructively challenge executive colleagues and seek assurances that clinical quality is embedded across the organisation.**

Lessons learned about the role and capabilities of nurse executives

Our observations suggest that nurse executives have a key role to play in:

- helping to create the right culture and climate to have open discussions about quality
- leading by example and constantly reinforcing the importance of clinical quality to all aspects of the business
- stimulating discussion about what types of information boards want and need to know in order to assure quality
- interpreting hard data and identifying the clinical impact
- serving as a conduit of information about the patient experience, through the use of soft intelligence and narrative
- helping boards to tap into the emotional content of the patient experience
- role-modelling appropriate behaviours around presenting and receiving negative feedback from patients.

From our observations, the following capabilities are important in order for nurse executives to work effectively with boards to secure improvements in clinical quality.

- Being able to talk convincingly about the business of the whole organisation, and not limit their contributions to clinical issues.

- Being able to draw on a wide range of capabilities, and employing a style, tone and body language that reflect authority, confidence and competence.

- Being able to draw on financial and commercial acumen, but also retain their unique clinical focus and emphasis on the human experience.

- Being able to nurture key alliances both within and outside the boardroom, which support them to be more confident and authoritative in discussing clinical quality at board level.

- Being supported by robust reporting processes around clinical quality and a boardroom environment that is open and interested in this agenda.

The next phase of the programme provides an opportunity to explore these emerging themes in more depth. We will report on our findings towards the end of 2009.

Appendix A

Table A1 Issues covered during board observation visits

Context	Board structure and dynamics	Nurse director
The context in which the board operates — eg, mergers, working under special measures, strong/weak financial footing, community focus	**Room layout** — who sits where and extent to which this facilitates discussion	**Presence** — eg, extent to which commanding presence, authoritative, etc
	Cast list — number of attendees, including the number of clinicians around the table	**Source of authority** — eg, breadth of portfolio, support of chief executive, role as nurse leader, responsibility for quality, patient champion
	Role/performance of chair — eg, facilitative, controlling, autocratic, chaotic, engagement in quality issues, patient focus, extent to which encourages discussion or moves members through agenda with speed	**Input** — quality of input, both invited and spontaneous
	Role/performance of chief executive — eg, extent to which visibly supportive of nurse executive, engagement in quality issues, patient focus	**Ability to focus on strategic issues** — extent to which focuses more on operational issues
	Organisation of meeting — public/private split	**Alliances with other board members** — particularly with medical director and other clinicians, extent to which work together and support each other
	Openness to public scrutiny — extent to which invites questions from public and responds respectfully/helpfully	
	How agenda is organised — eg, who speaks to what and for how long, order of items on the agenda (including, specifically, priority given to quality issues/patient experience)	
	Presentation of data relevant to clinical quality — who presents data, what format, mix of quantitative and qualitative data, use of patient stories, impact of data	
	Role/performance of non-executive directors — extent to which challenge executive colleagues, focus on quality, patient focus, familiarity with clinical terminology, comfort discussing data around clinical quality, response to data on negative outcomes	

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