Chapter 5. Decentring patient safety governance: Case studies of four English Foundation Trust hospital Boards

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Introduction

Hospital Trust Boards in the English NHS have statutory responsibility for upholding quality and safety of care in their organisation. Recent high-profile reports into serious failings in standards, most notably at Mid-Staffordshire NHS Trust, raise concerns over the ability of Trust Boards to discharge these oversight duties effectively (Francis, 2013). Despite a plethora of guidance on effective Board governance (NHS Leadership Academy, 2013), significant gaps remain in our understanding of what Board governance looks like, and the organisational processes and cultures through which it is discharged (Millar *et al*, 2013). The literature on Board governance of patient safety consists largely of quantitative cross-sectional surveys, predominantly undertaken in U.S. acute health care settings (Jha *et* al, 2005; Jha and Epstein, 2010, 2012, 2013; Jiang et al. 2008, 2009, 2011). While qualitative and case-study research is beginning to emerge (Baker et al. 2010; Ramsay *et al*, 2010; Mannion et al, 2015; Mannion *et al*, forthcoming; Freeman *et al,* forthcoming), further study of the practices undertaken in the boardroom is needed to provide insight into the exercise and experience of patient safety governance; the micro-processes associated with Board oversight (Dixon-Woods et al. 2012).

In this chapter we draw on the decentred governance literature (Bevir and Rhodes, 2003, 2006, 2010) as a framework to examine the enactments of Board governance of patient safety at four Foundation Trust hospitals within the English NHS. A decentred approach (Bevir, 2011, 2013; Bevir and Rhodes, 2003, 2006, 2010; Bevir *et* al, 2003) challenges reified classifications of governance, instead drawing attention to diverse governance practices; the understandings of those practices held by participants; and the contingent and contested nature of enactments of those practices within narrative traditions (Bevir, 2013). Situated agency is placed at the heart of analysis, explicitly incorporating the beliefs and actions of actors as a motive force and thereby recasting governance as an active process of local *instantiation* – one requiring the continued enactment of historically situated patterns of understanding through iterative citation of behaviours readable by others as governance; an imbrication with the possibility of misreading at every 'performance' (Freeman and Peck, 2010), manifesting as diverse practices given the possibility of challenge and resistance from alternate narrative traditions.   Decentred governance thus shifts methodological focus to the every-day accomplishment ('performance') of governance; the beliefs, traditions, dilemmas and situated behaviours of agents, and the conceptual frames and narratives drawn on to inform action. Social formations (regulatory bodies, networks, Boards of directors) are recast as fluid and contingent processes; informed by historically located narratives, yet fashioned through situated local agency – as sets of cultural practices – and decentred to facilitate exploration of the practices and actions of which they are constituted. The role of the analyst is thus to explore contingent patterns of action in historical context, and the narratives by which actors make sense of their world and seek to engage with it (Bevir, 2013). Where these contexts are framed as traditions, theories or narratives and which may themselves be transformed through situated agency in circumstances where agents respond to dilemmas arising from experience or reflection on prior beliefs.

Taking care to contextualise our analysis through this de-centred approach, our chapter explores conceptual framings of corporate governance that may inform local practices, and outline the regulatory context of patient safety governance within the English NHS. We then empirically explore the situated agency of Board members in relation to the governance of patient safety within four case study sites. Our chapter draws on the findings from a larger NIHR funded study of the governance of patient safety (Millar *et* al, 2013, 2015; Freeman *et al,* 2016; Mannion *et* al, 2016). Our analysis focused on the Board meetings at each of our four case study NHS Foundation Trust hospitals, focusing on Boards' use of patient safety data embedded within broader performance-management governance systems. Given our interest in the local instantiation of macro-level governance processes, cases were selected to reflect the diversity of English NHS Trusts: a district general; a teaching hospital with a global reputation for specialist services and innovation; a regional centre offering specialist services; and a Trust undertaking large-scale service redesign. Our analysis draws on composite qualitative data drawn from semi-structured interviews with Board directors (n= 57) and governors (n=8), together with data from overt non-participant observation of four sequential management Board meetings at each case study site.

Corporate governance

A range of competing conceptual framings have been used to understand the governance role of Boards (Cornforth and Edwards, 1998; Chambers *et al*, 2013), and which inform the situated agency of local actors. We outline these framings, situating them within the historically emergent governance narratives and drawing attention to the implications of each for hospital Board oversight of quality and patient safety.

Principal-Agent theory was developed within neoclassical economics to explore the operation of delegated decision-making within the private sector. Informed by rational choice theory, the approach explores the implications of informational asymmetry between principals (shareholders) and their agents (managers) from the initial premise that agents are self-interested and will seek to maximise their own advantage unless otherwise monitored and / or incentivised. By extension, when applied to public service provision in a manner consistent with early or 'first-wave' New Public Management reforms, principal-agent theory charges hospital Boards with holding employees to account for their performance, monitoring them, and incentivising required behaviours via reward or sanction in order to ensure accountability. Consequently, Boards are charged with the design, implementation and monitoring of processes and incentives that generate good quality care, underwritten by the external regulatory regimes considered in detail below (Chambers *et al*, 2013).

In contrast, *stewardship theory* contends that employees may be trusted to serve as stewards of an organisation's resources and can contribute towards the attainment of broad organisational goals (Chambers and Cornforth, 2010). Consistent with notions of a public service ethos and developmental historicist notions of a 'common interest', in this view the role of the Board centres on developing and nurturing shared organisational values and goals. While such positive orientations may be incentivised there is less emphasis on formal monitoring and / or coercion and greater appeal to notions of duty and responsibility for conduct consistent with the requirements of office.

Stakeholder theory is explicitly political in orientation and takes the existence of overlapping interests, both competing and cooperative, as a starting point of organisational life. Informed by modernist sociology's concern with interdependencies and social relationships, and associated with 'second wave' progressive governance reforms, stakeholder theory argues for greater efficiency and responsiveness of the basis of trust and participation. The implication for Board oversight of patient safety is the requirement to identify, address, integrate and balance different stakeholder interests. The role of the Board, then, is to interpret and represent the views of all those with a stake in ensuring the delivery of good quality care, brokering coalitions and trade-offs between stakeholders (staff, regulators, patients and the public) as required.

Originally developed within the strategic management literature (Zahra and Pearce, 1989), r*esource dependency theory* casts the organisation as a repository of tangible and intangible assets and capabilities. The Board is charged with managing internal and external relationships to maximise organisational influence and resources, Board members expected to use their skills and contacts to act as 'boundary spanners' with key partners to secure organisational resource, expertise and strategic advantage. While the approach has some affinities with 'second-wave' New Public Governance reforms, its focus is one of securing advantage for the organisation *vis-à-vis* other organisational actors, rather than brokering a new settlement within civil society. In terms of patient safety, it implies Boards activity to develop new ideas and skills (internal) and shaping impressions of organisation performance held by regulators (external).

Finally*, performative and symbolic* framings focus on the ceremonial value of Boards, exploring Board performances in terms of: the setting in which deliberations take place; the staging in terms of deliberate attempts to organise the interaction between participants by drawing on existing symbols; the scripting expected of actors involved in debates and decision-making; and the performance delivered in terms of the way interactions construct new knowledge, understandings and power relationships (Hajer, 2005; Hajer & Versteeg, 2005; Freeman & Peck, 2007, 2010; Freeman *et al,* 2015). To the extent that such framings are used to broker coalitions between stakeholder interests, such approaches are consistent with second-wave governance reform, and may alternatively be used analytically to explore situated agency (Freeman *et al*, 2016).

Used analytically, none of these framings of governance in and of itself captures the full range and richness of hospital Board governance; each is a lens which draws attention to some Board activities while obscuring others. In addition to their analytical use, each frame has potential as a *discursive resource* to inform the situated agency of those engaged in governance processes; a series of assumptions which actors may draw upon, each of which privileges aspects of governance dynamics while neglecting others.

As such, the influence of these rival framings on situated agency can result in different local instantiations of patient safety governance, albeit informed by broader historically situated narratives. Each implies a series of local practices in relation to the presentation and use of summary organisational performance data with the potential for challenge from alternate framings (Mannion et al, 2005). For example, situated agency informed by *agency-theory* concentrates attention on, and demands action in relation to, formal measuring, monitoring and reward / sanction processes as mechanisms for translating Board activities into action and holding agents to account. However, the same performance data may also be used through the *resource dependency* frame to very different ends, with performance data used to influence external stakeholders' perceptions of the quality (or otherwise) of services reflected in summary performance data. Similarly, from a *stakeholder* perspective these data may be used to convince a coalition of internal stakeholders to challenge the veracity of the accountability framework in which performance data is embedded.

In the above example the same summary data are used as a resource to different ends; the meaning of the data discursively positioned against ('made sense of in relation to') different sets of governance assumptions. The co-existence of multiple frames thus provides a rich resource to inform the enactment of governance of patient safety with performative implications; a simultaneous 'saying' and 'doing' with implications for the subsequent actions of others. Successful local enactment of frames is dependent on their being read as 'governance'- and their performative implications also being accepted - by other actors.

Governing patient safety: the English NHS regulatory regime

We next introduce the current internal (Board) and external regulatory environment of patient safety in the English NHS, against which the governance frames considered above may be enacted. Taking this as a point of departure, we explore the local enactment of Board governance within a series of case study sites and explore the extent to which local governance practices were informed by a range of governance theories.

Internal corporate governance (Board)

Local hospital Trust Boards were first introduced in the English NHS in 1990. This was derived philosophically from modernist economic rationalities underpinning first-wave governance reform and, in structure, from the Anglo-Saxon private sector unitary board model predominant in UK and US business (Ferlie et al. 1996; Garrett, 1997). The unitary board typically comprises a chair, chief executive, executive directors and a majority of appointed independent (or non-executive) directors. All members of the board bear collective responsibility for the performance of the enterprise (NHS Leadership Academy, 2013). This Board structure evolved into a hybrid model, from 2004, in which hospitals successful in

financial and clinical terms could apply to be NHS Foundation Trusts (FTs). These are independent public benefit corporations modelled on co-operative and mutual traditions and, at time of writing, encompass more than two-thirds of acute hospitals. They have a dual board structure; a board of governors (up to about 50 people) made up of people elected from the local community membership, and a board of directors (around 11 people) made up of a chair and non-executive directors appointed by the governors, and a chief executive and executive directors, appointed by the chair and approved by the governors. This evolved structure resembles the Anglo-Saxon unitary board model adopted by the English NHS in 1990, but nested within a two-tier European or Senate model, commonly found in the Netherlands, Germany and France. The Foundation Trust board governance structure thus signals a desire to focus on participation in the pursuit of legitimacy, justice and effectiveness – and to this extent exemplifies a concern with embedded social relationships associated with second-wave governance reforms.

External regulation (Monitor)

The English Health and Social Care Act (2012) encodes a series of quasi-market mechanisms consistent with first-wave governance reforms in relation to external oversight, and private provision of care services. The Act charges an arm-length regulator, Monitor, with assessing risks to NHS service provision regardless of the provider, publishing guidance in relation to identified risks, and oversight of the governance of Foundation Trust hospitals. Failure to comply with Monitor's requirements ultimately results in withdrawal of licence to provide NHS services. This licensing arrangement is the means by which private and not-for-profit providers gain access to the English NHS quasi-market of service provision. Monitor's Risk Assessment Framework (RAF) for Foundation Trusts provides guidance on the two conditions of the provider license: continuity of service (CoS) and governance

(known as condition FT4). Monitor undertakes a four-stage oversight regime in relation to the above conditions of tiered response, involving the annual monitoring of licence holders' strategic and operational plans, corporate governance and annual accounts; risk assessment of performance indicator data related to license conditions as above; undertaking investigations in relation to potential breaches of conditions; and ultimately enforcing regulatory action including suspension of management teams and withdrawal of license to operate. Routine risk assessment comprises an assessment of financial performance and Trust governance processes, any concerns triggering a dialogue between provider and Monitor to explore issues further and potentially resulting in enforcement measures. Governance is assessed via multiple methods, including specific metrics related to waiting times in A&E and for cancer services and hospital-acquired infection rates, third-party reports of infections, staff and patient satisfaction reports and HR data in relation to absenteeism and turnover, reports of third-party quality inspections and financial sustainability. Metrics are reported as a single global measure of 'green' (all clear), 'under review' i.e. concerns raised and steps agreed to ensure future compliance, and 'red' (enforcement action underway).

The local instantiation of Board governance of patient safety

Public service reforms in England typically emphasise performance and accountability, rather than renewal and entrepreneurship. One consequence of this is that lapses of control, rather than lack of attention to innovation, are more likely to be deemed governance failures. This long-standing emphasis on conformance may be traced in the development of, and the focus of attention paid to, internal and external governance arrangements in the English NHS over the past twenty years (Chambers 2011).

While the model exhibits strong elements of first-wave governance reform - including the use of arms-length regulatory agencies and performance indicator frameworks to assess compliance with service specifications within a quasi-market of service provision - a decentred approach requires that institutional patterns be teased apart and that the instantiations of situated agency be considered. Given the centrality of the collation and reporting of performance indicator data to the governance of patient safety within the English NHS context, we concentrate our attention on the local instantiation of this requirement. Our approach teases out differences in local practices associated with the collection and use of these data and the contingent instantiation of governance of patient safety within our case study sites. An outline of the specific local dynamics of decision-making at play within each trust is provided in table 3. For each case, we provide a brief outline of salient contextual factors, and then consider the perceptions, interpretations and reactions of Board members to the patient safety performance data available to them ('performance assessment – local traditions'); the practices participants deemed integral to the operation of Board governance at the site ('governance practices'); and their perceptions of the effects of wider regulatory environment ('regulatory regimes') on local governance practice.

Case 1: Arran

The trust is a renowned teaching hospital providing general and specialist services across multiple sites, and over the last five years Board membership has been stable. The executive team aims to continue to build its global brand as a provider of specialist services, and is addressing excess demand for local A&E services through large-scale service redevelopment. Organisational performance measured by Hospital Standardised Mortality Ratio (HSMR) is better than average, but the Trust has performance issues with regard to levels of staff satisfaction and, more recently, rising infection control rates.

Performance assessment – local traditions

Arran provided Board members with an information pack of performance indicator data, including patient safety and disaggregated by division, as an enclosure with Board papers. This information was reported to the Board as a standing item ('Performance Report') and was prefaced with a single (A4) summary page of Red-Amber-Green (RAG) 'traffic-light' metrics to concentrate attention. This level of detail is consistent with principal-agent theory in that it opens Board executives to scrutiny in relation to high-level outcomes for which they may be held accountable; and its provision gave considerable confidence to some Board members:

> '... it gives us a pointer in terms of who we should be speaking to, and there's some commentary in there as well and I place a lot of reliance on this, as I think many other people do.'

RAG ratings were supplemented by 'Care Thermometer' clinical data disaggregated by ward. While welcomed, some concern was expressed that both disaggregated data and RAG metrics was used in a reactive manner, opportunities for early intervention lost with an overtly assurance-focused framework:

> 'For the most part, we look back at what has happened and try and learn from it and then try and quickly apply, 'Oh if that's happened, what must we do looking forward'? If we were to aspire to the absolute best practice, which we do, there's something about tracking non-safety trends in an intelligent way that you can now do with the level of data capture and using it to predict where the might be a problem.'

Some concern was expressed about over-reliance on quantitative summaries and a reactive (assurance-focused) reporting system. Unannounced visits, ongoing complaints reviews and walkarounds were also used:

> *'The secret of it all is to talk to a lot of people because people will often tell you in conversation what they wouldn't tell you if they had to write a report about it or if it had to go through their line management process, wherever that line management process may apply.'*

Governance practices

Interviewees report increased Board time spent on quality and safety in recent years driven by the arrival of new, and clinically experienced, non-executive directors (NEDs). Overall, Board relations were described as good, with healthy challenge and debate alongside 'friendly fun and banter'. Board members described a feeling of 'openness' facilitating honest exchanges between executives and non-executives, in which NEDs could 'always speak absolutely freely and without consequence' and need not fear 'pulling their punches' in holding Executives to account:

> *'What I would say is that [NEDs are] pretty well empowered here. They are seen and treated with a lot of respect by the Executive. We don't always agree with everything they say, but when they say "jump!" to quite a large extent we jump.'*

Yet, this view was not shared by all; some NEDs expressed concern about their ability to hold executives to account in relation to patient safety, notwithstanding the detailed performance management data presented at each Board meeting. Far from being able to use such data to hold executives (agents) to account, one NED (principal) described watching an

increase in C. diff infections over time, trusting that 'the matter was in hand' but anxious that there was no data to support this view, nor an action plan to address it. This suggests that some NEDS at least felt unable to voice their concerns in relation to performance indicator data. In a similar vein, while noting a perceived increase in 'challenges' between Executives and Non-Executives as they sought to resolve ongoing organisational problems welcomed, such challenges had historically been perceived as disloyalty:

> *'I think we're only starting to get to a place where Execs can question one another, but I would say that's definitely an evolution. Previously, I'd have said that was almost unheard of, that would have been seen as being disloyal and, not career threatening, but just not done. That's – I would say that's definitely changed. So it's better than it was but I'd say it's got a way to go before you can speak freely.'*

Observational field-notes further reveal the rarity of such challenges between Board members over successive meetings. This was so even on an occasion when the CEO reported infection rate statistics in breach of regulatory limits, resulting in the need for intervention by the regulator (Monitor). Notwithstanding provision of summary performance indicator data within an internal reporting system explicitly designed to link internal assurance processes with external regulatory frameworks, the CEO was able to frame the interpretation of data in such a way as to forestall challenge – largely due to the placement of a 'CEO report' as an early agenda item, which afforded the opportunity to frame interpretations of information presented to the Board within later agenda items and forestall debate. In this instance, while data associated with performance was reported to the board, the adversarial challenge required for the operation of principal-agent theory became decoupled from the data. This may be due in part to a concern that such action may be interpreted as disloyalty; and in part to concern over the way in which the external regulatory regime framed the target (below).

While external performance targets had been embedded into internal Board reporting practices, breaches of performance targets did not necessarily result in adversarial challenge at the Board, as considered above. Rather, questions were raised about performance targets established in relation to C. diff and MRSA infection control. The Board were in discussion with Monitor about the recent breach in this area: indeed, the view that Monitor did not take into consideration the specialist, tertiary nature of the Trust, and its policy of admitting patients from other hospitals that already had infections, prevailed at a time of a breach of targets, and the CEO was not challenged on this view (Freeman *et al,* 2016).

Case 2: Skye

Skye is a District General Hospital (DGH) Trust providing services across two sites and achieved Foundation status early. Over the past five years the Board has been characterised by continuous change with the arrival and departure of several Chief Executives, Medical Directors and Nurse Directors. The Trust has one of the highest patient demands in the country and faces challenges related to bed capacity. Organisational performance was a cause for concern with HSMR above average, high Accident & Emergency (A&E) demand, and increasing infection rates. Skye had struggled to successfully implement governance activities to ensure safe care due to a continuous turnover of Board members and the priority placed on finance by successive Board regimes.

<u>Performance assessment – local traditions</u>

Patient safety performance was seen as worrying, with both the HSMR and the SHMI (Summary Hospital-level Mortality Indicator) being above average.   Despite the availability of a quality dashboard and Disaggregated HSMR data, current benchmarking was considered poor, with mistakes in the reports endemic. More work was needed to improve the methodology as the accuracy of the data was currently being questioned.

> *'I think the business intelligence report isn't quality controlled brilliantly well. I'm fed up with spotting reds that should be green ... that needs to be tightened.'*

Given a lack of a consistent structure, when issues escalated to Board level the meaning of indicators was not clear and decision-making compromised; while data was available, concerns over its validity meant that it could not be relied on to trigger a response. Alongside quantitative data, Board members described use of soft intelligence through review of patient complaints, mock CQC assessments and walkabouts.   While some Board members were keen to introduce patient stories as a way for the Board to access more qualitative material, others expressed vocal opposition:

> *'It ends up with "Woe is me" and we end up spending half-an-hour to three-quarters-of-an-hour on a patient's story and it didn't actually make any difference to the patient, right? And the one thing that concerned me through all this was: "Where is the learning? Where is the continuous improvement? Where is the will to not make that mistake again? Where is the will to plug that hole and say that will not happen again?".'*

> *'The touchy-feely stuff... Yes. I'm a surgeon by trade, so I'm not good on touchy-feely.'*

Governance practices

Board practices conformed closely to an adversarial model consistent with first-wave governance reform, with Board Leadership typified by the vocal challenge of Executives by NEDS. The acting Director of Nursing, new to the position, reflected on the difficulties of responding to such challenges. Being in an acting position, she noted, 'made it a hugely vulnerable and exposed place to be' as the NEDs attacked her inexperience. NEDs very much believed that challenging the executive was an important part of their role. However, they struggled to hold the Medical Director to account as they lacked the necessary clinical knowledge. 'Second guessing clinicians' was an ongoing struggle; having greater clinical knowledge in the board room was seen as necessary and the Board were exploring the use of clinical directors to forward service changes and harness clinical and corporate governance.

Regulatory regimes

The financial penalties for non-compliance with targets in the external performance management regime, while informing the Board's previous emphasis on finance and cost-control, had resulted in instrumental Board behaviours focused closely on the 'financial baseline rather than worrying too much about quality'. Respondents acknowledged that targets – and associated financial penalties - did focus the mind; and being held to account through Monitor's compliance framework was broadly accepted as a reasonable approach. However, the current compliance framework continued to create dysfunctional consequences. As the organisation was in breach of its C. diff target, the financial penalties represented a key issue for the Board. Frustrations included the lack of consultation regarding how the target was formulated and the relatively small margins of error. The lack of dialogue

regarding the target was having a demotivating effect and potentially turning people off infection prevention as 'we've been set up to fail'. The Trust was eventually able to negotiate the penalty with the CCGs but the maximum fine would have completely wiped out their surplus and put them into deficit.

Case 3: Lewis

Lewis is one of the largest NHS Trusts in England and delivers services across multiple sites. It offers one of highest number of specialist services in the NHS with a large consultant body acknowledged as being at the 'cutting edge' of clinical care. It has a long-standing reputation for high quality clinical care; Board members attributed their success to the leadership of the Chief Executive who had shaped the strategy and ethos of the organisation.

Performance assessment – local traditions

Board members expressed confidence and support in the 'good reports and regular dashboards' that were provided as Board papers to support each meeting. In addition to mandated performance measures, Board members had access to data from the Clinical Assurance Toolkit (CAT), a monthly online survey of clinical quality assurance measures, and benchmark data against other FTs. However, concerns were raised about the amount of information Board members had to read in advance of and during Board meetings and Directors also indicated the danger of reliance on 'high level' in the absence of disaggregated data; particularly with regard to hidden difficulties:

> *'The corporate governance committee spends quite a lot of time fretting about the corporate risk register. Are we looking at the right things? ... What about the stuff in the middle ground? ... Something ticking away there that's been running for months or even years, that might actually be more of a concern... and I worry about some of those things from a governance perspective because people tend not to keep their eye on those so much.'*

Walkabouts were cited as something the Board regularly carried out, but again anxieties were expressed by a NED that they were 'never quite sure of what's going on' therefore a 'certain amount of wit' was needed to understand the high risk areas. Additionally, further work was needed in relation to staff communication and engagement:

> *'I, personally, feel that there should be more Board-to-ward communication... some of them, I think, don't actually... They're a bit frightened of it.... I think some of them feel out of place. It's a bit like putting a barrister in an operating theatre – they're fine in a courtroom, but you put them in an operating theatre and it's a different ball game.'*

<u>Governance practices</u>

While some described Board meetings as predominantly focused on quality and safety issues, observation data indicated that considerably less time was proportionately spent on this issue at Lewis than at the other three case study sites (table 4), with large amounts of time also spent on estates. Some executives expressed the view that more discussion could be given to quality and safety:

'I don't think that there's enough discussion at the Board about the clinical issues and quality issues. I think there's far too much concentration on politics and buildings and arguments about the office block and all this sort of stuff, which are important from the organisation's point of view – there's a lot of money associated with them – but I think the Board agenda is dominated by those issues.'

While NEDs confidently expressed the view that they were able to challenge and hold the executive to account, consistent with first-wave governance reforms in relation to the functioning of the corporate Board, others expressed the view that the CEO dominated Board meetings and that more challenge was required in order to act as a break on the executive:

'I don't think the challenge is there. And I think that's because it's so dominated by the Chief Executive. Please don't get me wrong – I'm not saying he's not right or that he's bad for the organisation. You can see very well that he isn't bad for the organisation. I just... I think the Board would be healthier if there was more challenge from the whole spectrum of Board members rather than it being so dominated by one person. And I think some of that comes down to his personality, some of it comes down to relatively weak chairing.'

Observation data indicated that much of time was spent in monologues by the CEO on 'matters arising' particularly in relation to estates and service reconfiguration. These typically drew on governance narratives informed by appeals to the defence of the 'common good' of the local population against external (regional and national) imposition, in which the CEO presented himself as the embodiment of such local interests.

While valuing Monitor as a 'genuine independent regulator' and acknowledging that compliance targets had driven improvements, the threat of financial penalty per case of C. diff over target trajectory had negative consequences for services delivery. Observation data revealed the time, energy and passion spent on challenging the threat of financial penalty, with local relationships brought under strain from the threat of legal action by the trust. Indeed, narratives of the need for Board to defend 'local interests', consistent with emergent historicist notions of defence of the 'public good', were commonly invoked.

Case 4: Islay

Islay is an integrated provider of hospital, community and primary care services. It has a high national profile, and has received several awards, for its achievements in promoting quality and safety. The Trust is widely acknowledged to be among the leading organisations in England for both patient and staff satisfaction.

Performance assessment – local traditions

The organisation had been a forerunner in developing a quality assurance framework that combined national level data regarding HSMR and SHMI with additional local data such as the Nursing Assessment and Accreditation System (NAAS) and Quality Improvement projects using Statistical Process Control (SPC) run charts. While these are all consistent with first-wave governance, Board members explicitly described triangulating this data with additional 'softer' intelligence obtained through walkabouts, Board briefings (project

managers presenting reports), and the complaints panel. Walkabouts in particular were highlighted as a good way to make the Board visible and as an opportunity to engage with frontline staff and to respond immediately to their concerns; a hybrid approach in which first-wave governance techniques were complimented by second-wave governance concerns to build coalitions for change embedded in social relationships:

> *'I think that regular attendance on the shop floor gives us a level of information and knowledge that we otherwise wouldn't get … and I think that that gets pulled back into the discussions that we have at Board level.'*

While the current performance information and quality indicator dashboard was in large part supported, some NEDs called for increased narrative interpretation and analysis of the statistics and summary graphs, and for more time at the Board to 'think about the implications' of the data. While disaggregated data was the ultimate goal, this information needed to be presented in an accessible way to better facilitate the operation of NED scrutiny of the executive:

> *'People would probably like the graphs, but I couldn't give two hoots about the graphs because words mean more to me. So to tell me what that actually means. Is it good, bad or indifferent? Have we gone up? Have we gone down? What is the trend?'*

> *'...looking at these graphs are leaving us cold. We've been doing it for three years, we see eight data points above or below, and then it drops down, great, what does that tell us?'*

Rather than more training in SPC methodology, NEDs reported that they wanted more time to develop relationships within the organisation; a call for even more second-wave governance in the hybrid mix.

Governance practices

Quality and safety issues were described as being the core business of the Board meetings at Islay, with the first part of meetings given over to presentations about the progress of ongoing quality improvement activities; observational data confirms this opinion (Table 2). One feature of Board meetings at Islay was the participation of all divisional directors in the first part of Board meetings, to create an opportunity for the Board to directly hold the divisional directors to account for the quality/safety performance of their divisions. This approach effectively operationalised second-wave concern with building networks across professional boundaries *within* the organisation at the divisional level Observation field-notes detail instances of 'respectful challenge' in which questions were made in a spirit of mutual accountability and in a non-adversarial manner.

Islay was unique among case study sites in the presentation of a 'patient story' at the start of each Board meeting. The stated aim was to 'set the tone' for discussion and to focus the immediate attention of Board members on service quality and patient safety matters and foster reflection on the need to build coalitions for change across different stakeholder groups. While many found this helpful, some concern was raised over the emotional power of such stories and lack of time available to discuss their service implications. Observational fieldwork shows that the majority of time was spent on broad strategic issues such as hospital reconfiguration, developing strategic partnerships and strengthening links with the community sector.

<u>Regulatory regimes</u>

Board members echoed the opinions of respondents elsewhere that the Monitor Compliance Framework had 'focused the mind' in relation to key performance areas. The introduction of infection control targets for MSRA and C. diff, together with CQC criteria, had changed the way infection control was governed and effectively fused internal and external governance reporting mechanisms:

> *'You've got to take that as being a success. You know, there's no other way of saying that ... when we started with MRSA, we were probably having 80 [cases] a year… [but] we haven't had any this year ... So that, in part, has to be the fact that targets have been set.'*

> *'The first thing I look at in the Board pack is the infection control! And then I look at all the data, you know. So I think we are incredibly mindful of that.'*

However, the unintended consequences of focusing on performance indicators as an end in themselves was revealed when a service area) not covered by a Monitor or CQC compliance framework, the kitchens, breached environmental health regulations without warning

Discussion

The external regulatory environment of patient safety governance in the English NHS is strongly informed by first-wave governance reform narratives: collection of data on organisational performance indicators with reporting to an external regulatory body, and used as the basis for entry to (and continued operation in) a quasi-market of differentiated providers with the aim of stimulating efficiency and quality. Similarly, the adoption of the

unitary Board structure in the 1990 Health Act signalled an adversarial framing of interests consistent with principal-agent theory, and such adversarial framing was evident within our case study sites, notwithstanding the existence of a Board of Governors within a tri-partite structure intended to address second-wave concerns with building coalitions of stakeholders. While envisaged as a means to encourage and facilitate local stakeholder governance, FT Boards of governors at these sites were typically reported as largely ineffective; subject to capture by the Board and used to legitimate Board decisions with external stakeholder groups (Mannion *et al,* 2016).

Given the nature of the regulatory environment, it is hardly surprising that each of our case study sites sought to provide strategic assurance though a range of activities. These included the establishment of organisational processes for collating and reporting safety-related information to the Board and to external regulators; using high level information to ensure compliance with safe standards and meeting externally led targets; making patient safety a strategic priority; and interventions designed to encourage reporting of patient safety related incidents. Yet, despite a shared external regulatory framework for patient safety governance in Monitor and common guidance for the constitution of an adversarial FT Board, our case studies exhibited important variations in local instantiation of patient safety governance. Local actors' situated agency in the light of governance narratives clearly informed practices at each of our sites.

Our analysis reveals the Board governance of patient safety to be an ongoing process of enactments (instantiations) by actors drawing on a range of existing theories of corporate governance to inform their use of performance indicator data; and drawing on different narratives at different times to inform action. Board governance activities, then, were hybrid and applied contingently. Our case study sites show governance activities variously informed by p*rincipal-*ag*ent* theory in the use of performance data to ensure compliance and to hold

25

staff accountable for their actions; s*tewardship* theory in attempts to secure a framework of shared values built on trust-based relationships; s*takeholder* theory in brokering complex trade-offs between stakeholders; and r*esource dependency* theory, in managing internal and external relationships to leverage influence and resources.

Drawing heavily on first-wave governance narratives consistent with *principal-agent theory* to inform Board enactment, Skye was the most adversarial of our four case study sites. While the availability of summaries of quality indicators was a necessary cause, the adversarial enactment was distinctive, a consequence of perceived historical failures in data collection and fear of the financial penalties (negative incentives) of non-compliance with infection control performance targets. At this site, and despite fears over the validity of indicator data, breaches of compliance in RAF indicators were accepted and used to publicly hold the executive to account.

In contrast, and notwithstanding the common external regulatory environment, Board actions at Islay were informed by *second-wave governance* narratives to the extent that much energy was expended in the development of quality improvement methodologies. While RAF performance data was gathered and monitored as mandated, it was used in the context of the Trust's strategic improvement plan to build coalitions for ongoing local quality improvement. In this context, challenge was legitimated as an important precursor to process improvement, welcomed by the CEO and enthusiastically embraced by NEDs. While there were no breaches in RAF indicators, performance against infection control indicators was used to inform and evaluate continuous process improvements; regulatory compliance secure as a consequence of the primary goal of improvement. A very different approach to RAF infection control indicators is evident at Lewis. Here, stakeholder theory was invoked to mobilise internal opposition and build coalitions to challenge the validity of local infection control reduction targets and seek legal redress for perceived inequities.

While on the face of it Arran adopted an assurance focussed approach informed by first-wave governance in which a wide range of performance data was made available to directors and discussion framed in terms of shortfalls on RAG indicators, the CEO was able to shape interpretations of performance data so that information which could have been used to challenge executive performance was interpreted as 'misleading'. This was achieved primarily through by invoking developmental historicist notions of stewardship in relation to the global reputation of the Trust for clinical excellence, in which challenge risked being seen as 'disloyalty'. Additionally, the CEO at Arran invoked *resource dependency* theory in his response to RAF breaches in infection control data, seeking to exert influence internally and externally to interpret the breaches as invalid and thereby avoid the consequences of regulatory non-compliance.

Conclusions

This chapter has explored *in situ* the messy, contingent and contested way in which hospital Boards perform and practice governance differently across a range of organisational contexts. In doing so we have approached Board governance as a bottom–up, negotiated and deliberative process which is continuously being created, sustained and modified through a multiplicity of socially situated narratives and meanings which inform actions and polices related to patient safety. Clearly our study aligns with many of the ontological and epistemological assumptions of the decentred approach to governance, and in particular its rejection of reified and totalising notions of governance prevalent in previous (modernist) empirical studies on this topic and promulgated through official guidance. Our study provides an empirical contribution to the decentred governance literature in terms of detailed consideration of the instantiation of governance within specific locales. It reveals the

heterogeneity of such instantiations in different locales and the fluid, contingent and enacted nature of social formations such as Boards and regulatory authorities. Additionally, we argue that the reframing situated agency as embodied practice – and thus subject to alternative readings from different perspectives - avoids the charge of idealism in which agents appear free to change the world in the manner of their choosing.

Bibliography

Baker, G.R., Denis, J.L., Pomey, M.P. and MacIntosh-Murray, A. (2010) *Effective Governance for Quality and Patient Safety in Canadian Healthcare Organizations: A Report to the Canadian Health Services Research Foundation and the Canadian Patient Safety Institute*, Ottawa: CHSRF/CPSI

Bevir, M. (2011), 'Governance as Theory, Practice, and Dilemma' in M. Bevir (ed.), The Sage Handbook of Governance (London: Sage), 1-16

Bevir, M. (2013) *A Theory of Governance*, Berkeley: University of California Press

Bevir, M. and Rhodes, R.A.W. (2003) *Interpreting British Governance*, London: Routledge

Bevir, M. and Rhodes, R.A.W. (2006), *Governance Stories*, London: Routledge

Bevir, M. and Rhodes, R.A.W. (2010), *The State as Cultural Practice*, Oxford: Oxford University Press

Bevir, M., Rhodes, R.A.W. and Weller, P. (2003), Traditions of Governance: Interpreting the Changing Role of the Public Sector in Comparative and Historical Perspective, *Public Administration*, **81**, 1-17

Bourgon, J. (2007) Responsive, Responsible and Respected Government: Toward a New Public Administration Theory, *International Review of Administrative Sciences*, **73**, 1, 7-26

Boyne, A. G., 1998. *Public choice theory and local government: A comparative analysis of the UK and USA*, London: Macmillan

Chambers, N. (2011) Leadership and Governance, in K. Walshe and J. Smith (eds) *Healthcare Management*, (2nd edition), Maidenhead: Open University Press, 377–400

Chambers, N. and Cornforth, C. (2010) The role of Corporate Governance and Boards in Organisation Performance, in Walshe, K. & Harvey, G. (eds.), *From Knowing to Doing: Connecting Knowledge and Performance in Public Services*, Cambridge: Cambridge University Press, 99–127

Christensen, T. and Laegreid, P. (1998) Administrative Reform Policy: the Case of Norway, *International Review of Administrative Sciences*, **64**, 3, 457 -75

Cornforth, C.J. and Edwards, C. (1998) *Good Governance: Developing Effective Board-Management Relations in Public and Voluntary Organisations*, London: CIMA Publications

Davies, H.T.O., and Mannion, R. (2000) Clinical Governance: Striking a Balance between Checking and Trusting, in Smith, P. (ed.) *Reforming Health Care Markets: An Economic Perspective*, Buckingham: Open University Press, 247–67

Denhardt, J.V and Denhardt, J.V. (2000) The New Public Service: Serving Rather Than Steering, *Public Administration Review*, **60**, 6, 549-59

Dixon-Woods, M., Leslie, M., Bion, J., and Tarrant, C. (2012) What Counts? An Ethnographic Study of Infection Data Reported to a Patient Safety Program, *The Milbank Quarterly,* **90**, 3, 548–91

Francis, R. (2013) *The Mid Staffordshire NHS Foundation Trust Public Inquiry*, London: Stationery Office

Freeman, T. (2002) Using Performance Indicators to Improve Health Care Quality in the Public Sector: a Review of the Literature, *Health Services Management Research*, **15**, 2, 126–37

Freeman, T. and Peck, E. (2007) Preforming Governance: a Partnership Board Dramaturgy, *Public Administration*, **85**, 4, 907–29

Freeman, T. and Peck, E. (2010) Culture made Flesh: Discourse, Performativity and Materiality. In Braithwaite, J., Hyde, P. and Pope, C. (eds.), *Culture and Climate in Health Care Organizations*, Basingstoke: Palgrave Macmillan.

Freeman, T., Millar, R., Mannion, R., and Davies, HTO. (2016) Enacting corporate governance of safety and quality: a dramaturgy of English hospital boards', Sociology of Health and Illness **38**, 2, 233-51

Hajer, M. (2005) Setting the Stage: a Dramaturgy of Policy Deliberation, *Administration and Society*, **36**, 6, 624–47

Hajer, M. and Versteeg, W. (2005) Performing Governance Through Networks, *European Political Science*, **4**, 3, 340–7.

Hood, C. (1991) A Public Management for all Seasons? *Public Administration*, **69**, 3-19

Hood, C. (1995) Contemporary Public Management: A New Global Paradigm? *Public Policy and Administration*, **10**, 2, 104-17

Hood, C. (2004) The Middle Aging of New Public Management: Into the Age of Paradox? *Journal of Public Administration Research and Theory,* **14**, 3, 267-82

Jha, A.K., and Epstein, A.M. (2010) Hospital Governance and the Quality of Care, *Health Affairs*, **29**, 1, 182–87

Jha, A.K., and Epstein, A.M. (2012) Governance Around Quality of Care at Hospitals That Disproportionately Care for Black Patients, *Journal of General Internal Medicine*, **27**, 3, 297–303.

Jha, A.K., and Epstein, A.M. (2013) A Survey of Board Chairs of English Hospitals Shows Greater Attention to Quality of Care Than Among Their US Counterparts, *Health Affairs,* **32**, 4, 677–85

Jha, A.K., Li, Z., Orav, E.J., and Epstein, A.M (2005) Care in U.S. Hospitals—The Hospital Quality Alliance Program, *New England Journal of Medicine,* **353**, 3, 265–74

Jiang, H.J., Lockee, C., Bass, K. and Fraser, I. (2008) Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders, *Journal of Healthcare Management,* **53,** 2, 121–34

Jiang, H.J., Lockee, C., Bass, K and Fraser, I. (2009) Board Oversight of Quality: Any Differences in Process of Care and Mortality? *Journal of Healthcare Management,* **54**, 1, 15–30

Jiang, H.J., Lockee, C., and Fraser, I. (2011) Enhancing Board Oversight on Quality of Hospital Care: An Agency Theory Perspective, *Health Care Management Review,* **37**, 2, 144–53

Laffont, JJ, and Martimort, D. (2001) *The Theory of Incentives: The Principal-Agent Model*, Princeton: Princeton University Press

Mannion R, Davies H, Marshall M (2005) *Cultures for Performance in Healthcare*, OUP Press.

Mannion, R, Davies, HTO, Freeman, T, Millar, R. Jacobs, R, Kasteridis, P, 2015 Overseeing oversight: hospital board governance for quality and safety in the NHS, *Journal of Health Services Research and Policy,* 20, 1, 9–16

Mannion, R., Freeman, T., Millar, R., and Davies, HTO. (2016) Effective board governance of safe care: a (theoretically underpinned) cross-sectioned examination of the breadth and depth of relationships through national quantitative surveys and in-depth qualitative case studies. Health Services and Delivery Research, 4 (4)

Osbourne, S.P. (2006) The New Public Governance? *Public Management Review*, **8**, 3, 377-88

Osbourne, S.P. (2010) The *New Public Governance,* London: Routledge

Ramsay, A., Fulop, N., Fresko, A., and Rubenstein, S. (2013) *The Healthy NHS Board 2013: Review of Guidance and Research Evidence*, Leeds: NHS Leadership Academy

Robinson, M. (2015) *From the Old Public Administration to the New Public Service: Implications for Public Sector Reform in Developing Countries,* Singapore: UNDP Global Centre for Public Service Excellence

McCourt, W. (2013) *Models of Public Service Reform: A Problem-Solving Approach*. Policy Research Working Paper No. 6428, Washington D.C: The World Bank

Naschold, F. (1995) *The Modernisation of the Public Sector in Europe: A Comparative Perspective on the Scandinavian Experience*, Helsinki: Ministry of Labour

NHS Leadership Academy (2013) *The Healthy NHS Board: Principles for Good Governance*, London: NHS Leadership Academy, accessed at:

http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf

Pollitt, C. and Summa, H. (1997) Trajectories of Reform: Public Management Changes in Four Countries, *Public Money and Management*, **17**, 1, 7-18

Smith, M.J. (2008), Re-centring British Government: Beliefs, Traditions and Dilemmas in Political Science, *Political Studies Review*, **6**, 2, 143-54.

Wright, V. (1994) Reshaping the State: Implications for Public Administration, *West European Politics*, **17**, 102-34

Zahra, S. and Pearce, J. (1989) Boards of Directors and Corporate Financial Performance: a Review and Integrative Model, *Journal of Management*, **15**, 2, 291–334

Table 1: A brief summary of each case study site

Arran	'World-class provider', • Global aspirations built on Research & Development • Strategic focus; external horizon-scanning to secure compliance with policy directives and safeguard the self-image of the trust as a pre-eminent provider. • Strong 'shaping' steer by the CEO: low challenge by Non Execs and a strong medical executive team • Needing to address emerging performance issues while minimising damage to its 'world class' self-image
Skye	'Local service under pressure' • District general hospital trust (3 sites) • Rotating board membership for over 3 years. • A myriad of problems • Focus on internal problem solving, limited wider strategy • High internal challenge by Non Execs, a strong Chair, technocratic CEO finding his feet
Lewis	'Embattled regional powerhouse'

	• A large teaching hospital • Seen as the main regional provider • Dominant CEO acting as a political antagonist; defending local interests from competing regional and national forces • Estate, finance, and legal disputes

Islay	'Faith in quality improvement methodologies'
	
	• A district general hospital trust
	
	• An 'intelligent' board
	
	    – Reasoned and assured questioning by Non-execs;
	
	    – CQI culture;
	
	    – Emphasis on patient experience
	
	• Strategic focus
	
	    – reconfiguration and integrated care strategies
	
	    – Clinical oversight
	
	    – divisions 'invited' to provide updates

Table 2: Summary of Board time by topic area across all 4 observed meetings

Topic areas	Arran		Skye		Lewis		Islay	
	Mins	(%)	Mins	(%)	Mins	(%)	Mins	(%)
Service quality, patient safety, performance measurement, risk	252	(60)	379	(42)	236	(28)	448	(54)
Strategy and capacity	30	(7)	185	(21)	158	(19)	315	(38)
HR	56	(13)	79	(9)	13	(2)	31	(4)

Finance	83	(20)	55	(6)	105	(12)	28	(3)
Estates	-	-	-	-	198	(23)	8	(1)
Other	-	-	194	(22)	130	(17)	-	-
Total	**421**	**(100)**	**892**	**(100)**	**845**	**(100)**	**830**	**(100)**

The table summarises the amount of time spent in minutes (% of total time) on specific, frequently occurring, topic areas within each case study site, totalled across all of the 4 Board meetings at each site. All devoted considerable time to issues of service quality, patient safety, performance measurement and risk, and this composite measure took the longest amount of time of at each of the sites.