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Bridging existing governance gaps: five evidence-based actions that boards can take to pursue high quality care

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Abstract

Objective. To explore the impact of the organisational quality systems on quality of care in Victorian health services.

Methods. During 2015 a total of 55 focus groups were conducted with more than 350 managers, clinical staff and board members in eight Victorian health services to explore the effectiveness of health service quality systems. A review of the quality and safety goals and strategies outlined in the strategic and operating plans of the participating health services was also undertaken.

Results. This paper focuses on the data related to the leadership role of health service boards in ensuring safe, high-quality care. The findings suggest that health service boards are not fully meeting their governance accountability to ensure consistently high-quality care. The data uncovered major clinical governance gaps between stated board and executive aspirations for quality and safety and the implementation of these expectations at point of care. These gaps were further compounded by quality system confusion, over-reliance on compliance, and inadequate staff engagement.

Conclusion. Based on the existing evidence we propose five specific actions boards can take to close the gaps, thereby supporting improved care for all consumers.

What is known about this topic? Effective governance is essential for high-quality healthcare delivery. Boards are required to play an active role in their organisation's pursuit of high quality care.

What does this paper add? Recent government reports suggest that Australian health service boards are not fully meeting their governance requirements for high quality, safe care delivery, and our research pinpoints key governance gaps.

What are the implications for practitioners? Based on our research findings we outline five evidence-based actions for boards to improve their governance of quality care delivery. These actions focus on an organisational strategy for high-quality care, with the chief executive officer held accountable for successful implementation, which is actively guided and monitored by the board.

Additional keywords: clinical governance, leadership, quality and safety, quality systems.

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Introduction

The recent review of hospital safety and quality assurance in the state of Victoria[1] and the 'Better Safer Care' response from the Department of Health and Human Services,[2] highlighted the essential role of governing bodies in safe, high-quality care delivery. Although public healthcare governance structures vary between the Australian states, given previous enquiries,[3–5] this message is applicable throughout Australia. The Australian Commission on Safety and Quality in Health Care emphasises that boards must ensure that: 'effective safety and quality systems and robust organisational governance practices are in place; safety and quality is monitored; and the organisation responds appropriately to safety and quality matters'.[6 p.2] Although there is evidence of a link between board attention to quality and safety and the provision of safer care,[7] there is limited information on the specific actions that health service boards can undertake to positively influence quality of care. We use the results of a qualitative study in a sample of Victorian health services to identify gaps in the implementation of quality and safety systems. For this study, 'quality system' was defined as: 'a systematic, coordinated, organisation-wide program of planning, governance, mind-set, behaviours, tools, change, measurement, evaluation and action to achieve and maintain the organisation's vision of a great experience for each consumer'.[8 p.8]

Methods

Participants

Eight Victorian health services volunteered to participate in this qualitative study to track the implementation and impact of their quality systems. The sample included one metropolitan specialist

health service, two large multicampus metropolitan health services, two regional public health services, one regional private hospital and two rural-based district health services. The data were drawn from two sources. The first was a review of the quality and safety goals and strategies outlined in the publicly available strategic plans of the participating health services. The second was a series of focus groups with a representative sample of board members and all levels of management, clinical leaders and frontline clinicians (doctors, nurses, allied health practitioners) from each hospital. Human research ethics approval was granted by La Trobe University and each of the participating health services between January and April 2015.

Focus groups

This paper reports on the baseline findings from the focus groups conducted in 2015, with 353 participants in 55 focus groups from the eight health services (Fig. 1). Participant numbers in each facility varied depending on the health service size.

Both authors jointly conducted 60-min focus groups. The health services, through the quality directors and managers, invited board members, managers, clinical leaders and clinicians by email to participate in the focus groups using convenience sampling. Clinical leaders were defined by the organisation, usually a clinician chair of a quality-related committee or national safety and quality standard lead or a clinical divisional head. Managers included all levels of management, including the chief executive officer (CEO), senior and middle managers. The invitation explained the research project and the health service's support to evaluate the status of their organisational quality system (which is a requirement for health service accreditation, as well as good management and governance practice). Similar to the researchers, the participating organisations wanted to gauge the success of the implementation of their quality systems and invited members of the board quality committee, senior and middle managers, clinical leaders and a sample of health professional direct care staff who would be available on the day the focus groups were scheduled. Given staff absences and changes, it is not possible to calculate a response rate and the researchers aimed to gather representative data by holding many focus groups, with relatively large numbers of participants for a qualitative study.[9]

The participants signed a consent form that the researchers kept separate from the focus group notes and no participant names were recorded. Focus group participants were assured their comments could not be identified. The structured focus group questions included:

1. Describe the components of your organisation's quality system.
2. What drives quality of care improvement in your organisation?
3. What difference does the organisational quality system make to the quality of patient care?
4. What is your role in the provision of high-quality care? How do you know this?
5. How does the quality system assist you in the provision of high-quality care?
6. How does your organisation define high-quality care?
7. What level of quality care do patients receive in your health service today? How do you know this?
8. Has the quality of care improved over the past 6–12 months? How do you know?
9. What would be helpful to you in further improving the care your patients receive?

The focus groups were not video- or tape-recorded to ensure full confidentiality of the participants. Both researchers took detailed notes. Although the researchers have had experience working in management and quality management roles in health services, there was no previous employee relationship with any of the sample health services. Following the focus groups the researchers compared the notes each had taken. The themes arising from the focus groups were clear and consistent, and data saturation was achieved in all health services after only a few focus groups, with those held after that point not raising any new issues or themes.

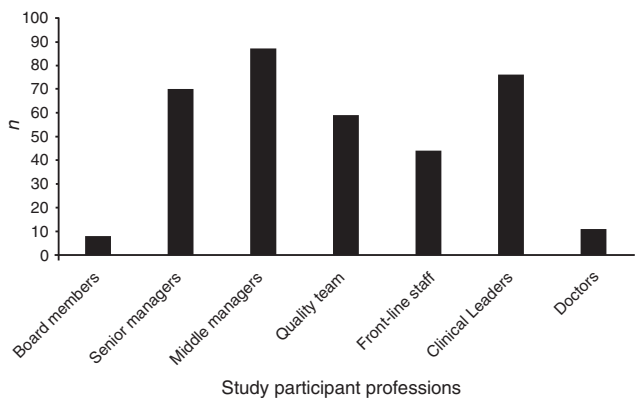

Fig. 1. Study participants by employment category.

Data analysis

Using content analysis,[10] the authors independently coded the qualitative data and then met to review and agree on the codes. The themes from the focus groups were consistently strong across the research sites, and there was little disagreement between the researchers on the key messages arising from the data collection.

Limitations

The study sample was skewed to senior and middle managers and clinical leaders, whose perceptions, as the primary implementers of any quality strategy, are extremely important. Both manager and clinical leader groups included doctors. We aimed to gather data from more board members, but access to them was more difficult, due to constraints on their time and limited availability. Following the consolidated criteria for reporting qualitative research,[11] open disclosure of the methods, a large sample and structured questions were used to minimise bias from self-selection of the participants and the perspectives of the researchers.

Results

Our data identified a consistent governance gap, in that all of the health services had difficulty translating board and executive aspirations for quality and safety into daily health service operations. This was compounded by quality system confusion,

over-reliance on compliance, and inadequate staff engagement. Each is discussed below.

Translation of board and executive aspirations for quality and safety into operations

Throughout the data collection, board members and senior managers consistently reported aspirational visions for high-quality care in their health service and pointed to a large number of documents on quality and safety. Unfortunately, these visions had not translated into everyday operations at point of care in any of the health services. As illustrated by these quotes, which were similar among metropolitan and rural and regional research sites, the vision was not generally well understood by local managers and frontline clinical staff, and was not embedded at point of care to guide decisions and actions. These quotes illustrate the findings that were consistent among different focus groups within the same health service, increasing the reliability of the data. Descriptive focus group names are in brackets after quotes.

> *We think that there is something written somewhere* [about the vision for quality of care]*. . . but we have demonstrated* [in this focus group] *that we do not know the expectations regarding the delivery of high- quality care.* (Clinicians Metropolitan8 FG#1)

> *I don't think I know what the board's vision and perspective* [on quality of care] *is.* (Clinicians Metropolitan6 FG#3)

> *We do not hear a lot from the board – we feed things up, but they do not feed back.* (Clinicians Metropolitan8 FG#2)

> *We send it up* [to the board]*, but we don't necessarily get it back down.* (Managers Metropolitan6 FG#1)

> *We have no direction for quality.* (Clinicians Metropolitan7 FG#3)

> *I do struggle with the quality stuff that comes through – I can't get my head around it.* (Clinicians Rural/regional5 FG#2)

> *Everyone has their own individual definition of safe, quality care.* (Clinicians Rural/regional2 FG#4)

Participants also expressed frustration at continually changing focus and priorities, as new quality and safety fads and methods were introduced, 'whatever the flavour of the month is for quality gets dropped on us' (Clinicians Metropolitan7 FG#5). We also found that at many of the sites, the responsibility for the quality of care often bypassed the operating hierarchy with the quality director or manager viewed as primarily responsible for 'quality and safety', usually through the pursuit of compliance activities.

The strategic plan review found that few of the sites had a documented quality strategy (i.e. a clear description of the desired quality of care to be achieved and key actions for achieving it) in the strategic plan. Five of the eight hospital strategic plans contained a high-level objective regarding quality of care, for example, 'quality and safety to the highest standard' or 'deliver excellent care in partnership'. Four of these provided information on what the strategic objective meant in practice, for example, 'patients receive help, treatment and information when they need it'. Only three of these strategic plans also included outcome statements, such as, we want our indicators to be consistently better than comparable benchmark rates. Despite the boards and executives being largely satisfied about their aspirations for quality and safety, the more common high-level big picture statements about 'excellence' provided little direction to clinical staff. This is not unique to Australian health services, with Baker and colleagues finding similar lack of specific targets and direction among Canadian hospitals.[12]

Even in the three health services with more detailed strategic quality objectives and strategies, most local managers, clinicians and frontline staff did not initially mention these when asked about their organisation's quality system. Staff believed that there were written documents that outlined their organisation's quality strategy but none could relate the details, nor knew how to access the information. Focus group participants appeared to be searching their memories for communications related to quality, and often recounted the organisational values (e.g. trust, caring, excellence and integrity) as the overarching organisational quality strategy.

In four of the eight health services, board members and senior managers recognised and described the 'patchy implementation' of their organisational quality system, and were developing plans to support a more thorough and meaningful implementation. In the remaining four, there were no formal plans in place to better engage with managers and staff to develop a shared understanding.

What is the quality system?

In the absence of strategic and operational guidance, staff defaulted to seeing their organisation's quality system as a series of committees, tasks and paperwork associated with compliance, such as incident reporting, reactive risk management, standards, audits and accreditation. This approach was often reflected in the organisational quality plans, which described the processes to be pursued, such as an audit schedule, data reporting and mandatory training, but seldom described how these activities supported staff to provide better care. Quality systems appeared to operate as transactional, highly regulated processes within a maze of policies, procedures, committee structures and reporting. Clinical managers and staff frequently noted that complicated bureaucratic processes associated with the quality system often discouraged them from initiating more meaningful monitoring and improvement activities in their services.

Many staff described their involvement in compliance tasks as 'doing quality'. This mindset appeared to contribute to the challenge of engaging them in meaningful point-of-care improvement.

> *Everyone is doing their quality part, plus their job.* (Clinicians Rural/regional2 FG#2)

> *The quality system is the schedule of audit reports we are required to provide.* (Clinicians Rural/regional3 FG#2)

> *Staff are busy doing the care, they often don't see quality as part of their job.* (Clinicians Rural/regional2 FG#7)

> *A lot of what we do seems to just be done for the doing.* (Managers Metropolitan7 FG#7)

Compliance

After more than a decade of clinical governance systems primarily focused on compliance and risk, quality agencies and commentators around the world recommend that boards and executives broaden their hospital quality systems to support the active pursuit of safe, quality care for every consumer episode.[13,14] However, the participants in our focus groups described their organisational quality systems as largely compliance-based, with improvement focused on meeting accreditation requirements. Clinical leaders, managers and staff complained that the compliance-based quality system did not assist them in planning and delivering high-quality care. Even senior managers often commented that 'the greatest leverage we have [for change] is compliance.'

Managers and clinical staff described that they were not engaged in quality and safety improvement because they were not asked to use their knowledge and experience to enact a vision for quality at point of care. They reported frustration about complying with a set of rules for risk management and accreditation purposes. For example, 'I am so busy trying to meet the expectations attached to the standards, I question if what I am doing is actually improving care delivery' (Managers Rural/regional1 FG#9).

The quality data reports received by boards were consistent with this focus on compliance. There was much discussion about specific indicators related to the national safety and quality standards,[6] such as falls and pressure injuries, consumer feedback scores and comments, and funding-related activity data. But this information did not enable board members or senior managers to take a broader view of what constituted quality care, nor determine the status of the quality of care provided in their hospital. No one in the board or executive focus groups could state with confidence if the quality of care in their organisation was improving.

Staff engagement

Health professionals must be actively engaged in the development of the quality system for it to be meaningful to their practice,[15] and focus group participants were asked about how they engaged with the quality system to support their provision of safe, high-quality care. The consistent answer across all participating health services was that the quality system was not helpful in any significant way. In fact, at all sites the majority of clinicians and managers told us that they felt that the quality system was imposed on them and noted the absence of a shared safety and quality agenda across their facility. In some cases they reported open conflict between priorities of the quality unit staff (quality directors, quality managers and quality facilitators), reflecting their responsibilities to pursue external reporting and accreditation requirements, and what the middle managers and clinical staff felt were the quality priorities related to their job and patient care. All were ostensibly pursing the same goal of ensuring good care, yet finding themselves at odds. For example,

> *It would be questionable what the quality department would do to help our QI* [quality improvement] *initiatives… if it is not on their agenda it's not going to happen.* (Clinicians Metropolitan6 FG#2)

> *There are difficulties in going against what the quality group have laid out for us*. (Clinicians Metropolitan7 FG#1)

> *It is difficult to get the floor staff out of the floor to 'do quality'. It is their* [floor staff] *perception that patient care is the priority and it has nothing to do with 'quality'*. (Managers Rural/regional2 FG#4)

This was compounded by the fact that few of the focus group participants could identify their specific roles in quality and safety, not helped by non-specific statements about 'involvement in quality' outlined in their position descriptions. Instead of explicit roles and responsibilities in providing safe, quality care, staff generally said that they 'just knew' their role or that it was 'their duty as a health professional' to provide quality care.

Discussion

Our findings suggest significant gaps between board and executive aspirations for, and expectations of, the quality of care in their organisations, and staff understanding and implementation of that vision at point of care. Although our findings largely relate to implementation, which the board delegates to management, 'the board does need to understand management's capacity to deliver the promised outcomes'.[16 p. 105] In this section we use the relevant literature to recommend five essential actions for boards to address the identified governance gaps.

Difficulty in translating board and executive aspirations for quality and safety into operations

Health service governing boards are accountable for the overall quality and safety of care that is provided by their organisation.[6,17,18] However, the gap we identified between the board and senior managers' aspirations for quality and safety and the ability of staff to translate this into day-to-day operations suggests that few boards were fully meeting this accountability. Millar and colleagues stress that 'board oversight of quality and patient safety rests on the directors' ability to obtain, process, and interpret information; assess current performance; and set strategic direction using a range of metrics tailored to local circumstances'.[19 p. 754] This is not easy for part-time board directors, many of whom are selected for knowledge and skills in areas other than clinical care, and it has been suggested that this has resulted in many public sector boards relinquishing, perhaps subconsciously, their quality of care responsibility to the clinical staff.[12] This leads to the first action: agree how your board will enact its accountability for ensuring the provision of high-quality care across the organisation.

Given the complexity associated with the healthcare system overall,[20] and the implications of this for creating consistently high-quality care and quality improvement,[21] it is essential that governing boards work in partnership with senior management and medical staff. The board is in the best position to influence the dual medical and management hierarchies,[22] to clarify the expectations, assign tasks and establish the mechanisms for accountability. We suggest that the recent major quality and safety review[1] and our research findings provide the opportunity for a frank discussion of the current status of an organisation's

care quality and safety, and the ways the board can assist in clarifying direction and expectations, and leading the improvement of outcomes. This would include agreement as to how best to include quality and safety on the board meeting agendas and identifying the orientation and development needs of board members in this area. A recurring theme in the literature from around the world is the ongoing need to enhance board members' awareness, understanding and competence in quality and safety.[7,12,19] One author even recommends exams for board members on the use and implementation of quality improvement as a requirement for improving hospital quality of care.[23]

In response to consistent findings that, in comparison to financial matters and government performance targets, hospital boards assign a lower priority to quality,[24,25] board and management must agree how much time will be devoted to quality and what information will be required to meet board accountability requirements. Governing boards also carry responsibility for ensuring the strategic direction of the organisation.[26] Boards, therefore, need to determine how and by whom the quality strategy will be developed and approved, and how the implementation and outcomes will be monitored. This leads to the second action: hold the CEO accountable for pursuing consistently high-quality care across the organisation.

The implementation issues we uncovered suggest that boards have not held their CEOs sufficiently accountable for translating and achieving a strategy for consistently high-quality care. The CEO is the person with the greatest impact on the quality of care within an organisation.[7] Hospital operations are controlled by dual management and clinical hierarchies,[22] and although it is those on the frontline that create the consumer experience, high-quality care requires shared acceptance of both the care expectations and the roles for delivery among clinicians and managers.[27] Despite clinician engagement being a key success factor for care improvement,[28] we found the requisite organisational roles and processes to facilitate clinician involvement[29,30] were often lacking.

We found that quality plan implementation was often delegated to the quality director or manager, signalling a misunderstanding of the business of healthcare. Although it is usually the responsibility of the quality manager to ensure that there is a functioning quality and safety system, in the same way that it is the finance manager's job to ensure an effective budget and financial management system, the quality manager cannot be the sole implementer. It is the role of line managers and clinical leaders, with direction from the CEO and senior management, to implement the organisational vision for high-quality care in their service, as they ultimately determine how care is delivered in their services.

The board members in our study were confident that the board and organisational managers were providing helpful signposts for staff, perceiving the quality documents that were in place to be sufficient. This supports findings of a survey of public health service boards in Victoria in 2013, that found board members were optimistic about the quality of care provided by their health service, that they had expertise in quality-of-care issues and that quality was a top priority for their board.[31] However, the same researchers also found 'a gap in the rhetoric of quality governance and the reality of month-to-month activities at the board level,'[32 p.1] which has been further supported by our results. There is little active translation from board to bedside. Some of the boards in our study understood that frontline staff had yet to fully grasp that providing and improving quality of care were fundamental parts of their job and not 'busy-work' activities. However others had little idea that staff were not engaged with deliberate actions to provide or improve quality of care. A recent systematic review of the literature looking at the relationship between governance and workforce outcomes stressed that 'governance mechanisms . . . should include explicit consideration of how the workforce can and will carry out their work in the ways intended',[33 p.492] but our study found few specific clinical governance mechanisms that point-of-care staff recognised as supporting them to provide good care.

Previous studies have highlighted that boards need to set ambitious goals for quality and use valid and reliable information to determine if the goals are being met and care is improving.[12] Nadler *et al.* stress that an engaged board needs to lead major strategic decision making, provide input to implementation and establish the measures and milestones to monitor implementation.[34] In our study, it was particularly concerning that when we asked board members and managers whether quality had improved in their hospital over the past 6 months, the standard answer was that no one really knew. Some board members told us that they had a 'sense of wellbeing' or 'their feeling is that quality has improved'. There were discussions about selected indicators that were trending in the right direction, but no one could authoritatively state that the overall quality of care had improved over the study period. This suggests the third action: outline an implementable and measurable strategy for actively pursuing high-quality care at all levels of the organisation.

Determining a strategy for improving quality of care is challenging for public health services,[35] and previous authors have identified how the craft production health professional model, with quality decisions made at the bedside,[36] makes quality planning difficult but essential.[37,38] It has been shown that better quality outcomes are achieved when a health service board spends more than 25% of their time on quality issues[7] and when the board has set and disseminated strategic goals for quality improvement.[7,25] Focus group participants repeatedly told us that their quality systems were focussed primarily on compliance, with insufficient attention on quality improvement.[10,11] This did not assist them, individually or collectively, to make decisions and take actions that would systematically improve care and create high-quality consumer experiences.

Research suggests that determining a strategy for quality of care needs to include the development of a concrete shared definition of the quality of care the organisation wants to achieve and be known for.[12,39] This definition is most effectively developed by involving staff and consumers, and must be simple,[6] relate to operations and be anchored in a strategy and systems for supporting staff to pursue it every day.[8] Our data suggest that general statements about 'high standards' and 'excellence' are not sufficient for managers and clinicians to select and implement actions required to achieve consistently good care. At our research sites, managers and clinicians frequently noted that they required more guidance about what constituted high-quality care and what to focus on in the midst of conflicting priorities and heavy workloads. In the absence of this guidance, critical actions required to ensure safe, high-quality care may be inconsistently

applied across the organisation, or missed completely, putting consumers at risk.

Quality system confusion and over-emphasis on compliance

Compliance activities, which were noted by focus group participants as the basis for their organisation's quality systems, although important, are not enough to ensure a high-quality experience for each consumer. These activities should be viewed as a means to an end, not an end in themselves. To engage staff in creating high-quality care-episodes for every consumer, the strategy must embrace a broader view of quality care, as defined by consumers and staff, that makes sense to those implementing it and be relevant to everyday work.

The type and quality of data collected in healthcare services influences the information that boards receive, and there are well-recognised challenges in accessing timely, leading indicators of quality in healthcare.[40] With the focus of current board reporting on compliance requirements, there is limited data and time for boards to address other aspects of quality important to consumers and staff. To adequately perform their fiduciary duty, boards must demand and become comfortable with 'problem-sensing' information, to move away from the current focus on 'comfort-seeking' measures,[39] which reinforce the status quo perception of, and satisfaction with, the quality of care in their organisation.[39] Some of these data are likely to be already be available in datasets not used by some organisations, and other elements would require longer-term planning and support to collect. The investment required would ultimately give boards a more comprehensive picture of the quality of care their organisation was providing, whether it was improving, and where to best focus attention, action and resources. This informs our recommended fourth action: actively monitor the quality strategy implementation, and respond proactively to progress and outcome information.

Inadequate staff engagement

Boards have a responsibility to ascertain to their satisfaction that consumers are central to the business of the organisation, that staff are supported to provide high-quality care and that systems and reporting are resourced and effective.[17] The board must ensure that there is an effective quality system in place that is designed, implemented and monitored to support the whole organisation to achieve the quality strategy. This is the final action: satisfy yourself that there is an effective quality system and appropriate culture in place to support the strategy for high-quality care.

There is substantial evidence that organisational culture must be conducive to enhancing quality and safety in order for this to happen.[41] Many participants in our study described a blaming, task-focussed and compliance-based culture that lacked key quality and safety culture requirements described in the literature.[42,43] Organisations devoted to good governance practice emphasise that boards must ensure that the appropriate organisational culture is in place.[17] Establishing the culture is a management responsibility,[44] but the board needs to agree on the desired culture and hold management accountable for implementation.[6] This suggests that the board needs to define clear cultural expectations, and regularly measure progress towards developing a culture that supports and achieves their strategy for consistently high-quality care.

Conclusions

Although Australia has a world-class hospital system, improvements in patient safety and quality care delivery have achieved fewer gains than expected.[1] In an attempt to determine possible reasons for this lack of progress, this study confirms that, despite the notable aspirations of boards and senior managers in relation to the quality of care they believe in and want to be delivered in their organisations, there are significant gaps between aspiration and practice. These gaps alienate staff and potentially put consumers at risk. Based on our findings that health service managers and staff want a shared vision of high-quality care, as well as clarity of their own responsibilities and the corresponding support required to enact them, we have outlined five essential actions to assist boards to close the gap and increase the relevance and robustness of clinical governance in the process:

1. Agree how your board will enact its accountability for ensuring the provision of high-quality care across the organisation.
2. Hold your CEO accountable for pursuing consistently high-quality care across the organisation.
3. Outline an implementable and measurable strategy for actively pursuing high-quality care at all levels of the organisation.
4. Actively monitor the quality strategy implementation, and respond proactively to progress and outcome information.
5. Satisfy yourself that there is an effective quality system and appropriate culture in place to support the strategy.

Providing consistently high-quality care is an ongoing challenge in the complexity of healthcare organisations. These five actions provide a robust platform for boards to pursue this through a deliberate, systematic and inclusive pathway.

Competing interests

The authors declare no conflicts of interest.

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