From Financial to Clinical? Perceptions and Conversations in NHS Boardrooms

Dr A Carter, Dr M Sigala, G Robertson-Smith, S Hayday

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NHS West Midlands

Burdett Trust for Nursing

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Dr A Carter
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Institute for Employment Studies

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Institute for Employment Studies
Sovereign House
Church Street
Brighton BN1 1UJ
UK

Telephone: +44 (0)1273 763400
Email: alison.carter@employment-studies.co.uk
Website: www.employment-studies.co.uk

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Executive Summary

Background

Boards play a crucial part in ensuring that the NHS performs effectively and is publicly accountable. Questions have been raised about their ability in the wake of failures in clinical care quality. There are concerns about boards' lack of attention to quality and clinical issues as opposed to financial and operational issues. In the West Midlands work was already underway on leadership, quality and other related matters, but its importance was thrown in to sharper focus by the Healthcare Commission Report in to Mid Staffordshire NHS Foundation Trust. How can NHS boards really make the patient quality, safety and experience agenda work? Starting in 2009, The King's Fund ran a Burdett Trust nurse executive and trust board development programme within the West Midlands. In January 2009 IES was commissioned by the West Midlands Strategic Health Authority (SHA) to develop a methodology to study and evaluate the first programme cohort of eight NHS boards.

Research aims

The study is evaluative in seeking to identify if attitudinal and behavioural change outcomes from the programme can be identified. From the outset the study also sought to gain a deeper understanding of how NHS boards engage with clinical issues, and so contribute to knowledge on what makes a board effective.

Key questions were discussed and refined with the study sponsors. Three research questions emerged:

How **rich is the dialogue about clinical issues** in the boardroom and did the dialogue change following the programme?

How does the way a board works influence the **conversations about clinical issues**?

Is there evidence of **changes in levels of clinical engagement** following the development programme? Do individual members think they are more 'clinically engaged'?

About this study

This study looks at what NHS boards do and how they take account of clinical issues. The study focuses on outcomes. A mixed methods approach was adopted comprising detailed examinations of board conversations and the views of individual board members.

We conducted an ethnographic-type micro-practice examination of the discussions at six board meetings in three different trusts. Board meetings were recorded and transcribed before and after the programme: some 750 minutes of boardroom conversations.

The quantitative research was an assessment of behavioural changes over time. Through on-line surveys, we gathered data measuring board members' clinical engagement and commitment levels. The surveys included statements about patient care, patient safety, the nurse director's role, the board's working, and communications. Seventy-one executive and non-executive members responded (about 50 per cent) to the pre-programme survey. The post-programme survey generated a 30 per cent response rate (33 responses).

Key findings

The vast majority of respondents reported positive outcomes from the development programme; a small minority were underwhelmed by the programme.

Our survey findings show that during the programme and afterwards there was increased clinical engagement self-reported by board members: there was an 85 per cent rise in the mean level of agreement on each of the measured clinical engagement statements. On 47 out of the 55 statements mean levels of agreement increased in the clinical engagement categories: levels stayed the same on three statements and decreased on five statements. On average, then, responding board members do perceive themselves as more clinically engaged.

Further analysis and comparisons between the surveys also show:

- nurse executives' greater confidence in raising items and answering questions on clinical care issues and when describing organisational processes such as those around monitoring performance
- greater receptiveness of board members to what nurse executives have to say

- a rise in the boardroom profile of patient safety and quality issues
- board members' greater confidence in the information they receive and much more positive perceptions about their ability to reach out to their organisations
- primary care trust (PCT) respondents feel generally positive about quality within commissioned services and in-house providers.

Through analysis of the transcripts we also found:

- board meetings got longer, possibly indicating greater involvement in, and discussion of, agenda items
- board members with clinical responsibilities had an increased volume of contributions, through a greater participation in discussions or more reporting
- clinical board members (ie nurse executives, medical directors and chair of the Professional Executive Committee) had increased interactions with non-clinical members.

We also looked at how board operating processes and interactions between key players, can affect boardroom clinical discussions:

- Putting quality and patient safety items early on the agenda encourages board members to engage with, and discuss, these issues for longer.
- The chair dictates the allocation and sequence of turns and the pace of the interaction. This determines whether clinical issue discussions take place and, if they do, their nature and duration.
- Collaboration between a chair and nurse executive discourages discussions from revisiting reports' detailed content, instead allowing space for larger, strategic macro enquiries (about dissemination and quality assessment).
- A topic can be introduced as a clinical one, but whether or not an item on the agenda will be discussed from a clinical perspective depends on members' responses, possibly shifting attention away from patient- and care-related implications.
- Non-executive directors (NEDs) challenge and scrutinise; this often results in a defensive answer from the person who has raised an issue. NEDs, therefore, play an important role in steering a discussion.
- Discussions rely on disagreement and contradictory positions to progress but, where the language masks that conflict, more members join in and the discussion is prolonged.

- Clinical board members are comfortable and confident when dealing with positive aspects, actions and lessons learnt about patient complaints, rather than when dealing with patients' negative experiences.
- Non-clinical board members are more engaged in talking about patient complaints when these are treated as technical products of performance monitoring and benchmarking, rather than as failures in patient care.
- The introduction of agenda items by a clinical board member can assume that the accompanying reports are easily understandable to other board members. Lack of understanding hampers constructive, effective discussion about clinical issues.
- Patient stories are powerful tools, but they can be used to support conflicting points of views on patient care. Financial discourse has more persuasive power in the boardroom.

Implications for research

Researching patient quality, safety and experience

It is not hard to envisage how NHS changes, and any disruption during implementation, might negatively affect clinical quality. While the evidence base is growing on how current boards can assure the delivery of patient care quality, we don't know how this duty will be affected by the changes to come. More research will generate data and develop guidance on the quality agenda in the context of major change. Questions needing investigation include:

- How can NHS organisations keep care quality central when services and organisations are under pressure?
- What is the impact on patient experience when organisations are making savings?
- What will GP consortia boards need quality standards to be? What will be the impact of gaps in service quality?

Methods in leadership research

We are not the first to use an approach where directors or managers have been recorded interacting with each other. Using this approach on multiple NHS board meetings has been different. It represents a shift away from the common approach of *asking* board members questions during in-depth interviews to *seeing* and *hearing* them operate over a period of time. In this research what we primarily hear is directors and senior managers talking to each other. We adapted the

theoretical and methodological approaches taken from conversation analysis and discursive psychology of the micro-practices that characterise pair processes in a work setting for use on board meetings' group processes.

We suggest that a micro-practice study of board members' conversational patterns, a focus on *what* they are talking about and *how* relevant knowledge and/or experience are deployed to influence boardroom process, is a useful contribution to researchers' options.

Implications for practice

A pattern we saw was that clinical members had trouble bringing patient voices into the boardroom. We feel this is important: until boards can see things from the patient's perspective, are they really going to tackle safety and quality issues? In an evidence-based culture, where quantification is favoured, patient stories can be treated as inferior and biased evidence. Boards need to be persuaded that such stories are important, and executives need to be further helped in this respect.

Our understanding is that, in the West Midlands, from June 2011 there may be a single executive team for each of the cluster boards of merged PCT groups. They will have a two-year remit, and they will have responsibility for patient safety and quality. GP consortia are being set up and developed, and will have budgets from April; they may take on complete responsibility for commissioning.

Advice from those involved in our evaluation suggests that these new organisations should focus on the right membership of the boards and consortia, including a specific person to lead on quality; use of standardised information and reports to tell them what's going on in a consistent fashion; embracing a level of external scrutiny in consortia; and taking time out as a board at some point during the first six months to focus on quality, the patient experience and how this feeds into the board's decision making.

1 Positioning the Study

1.1 Introduction

Board effectiveness is a hot topic and particularly scalding in two sectors. The first is financial services, following the failure of investment strategies (widely blamed for triggering the current 'age of austerity') and the subsequent failure of bank boards to change the culture of large bonus payments. The second is the NHS, where widespread criticism has been levelled in the wake of several 'scandals' due to failure of clinical care quality and ongoing concerns about the lack of attention NHS boards have given to quality in comparison with financial and operational issues. In the West Midlands work was already underway on leadership, quality and other related matters, but it's importance was thrown in to sharper focus by the Healthcare Commission Report in to Mid Staffordshire NHS Foundation Trust.The necessary corporate systems for quality are believed to be in place, so how can NHS boards be helped to improve their management and leadership of the quality agenda? And how can the nurse executive role be better used in enabling board colleagues to become fully engaged with the quality agenda? How can NHS boards really make the patient quality, safety and experience agenda 'work'? A Burdett Trust nurse executive and trust board development programme to address these issues was run by The King's Fund with nine organisations from across the West Midlands during 2009-10.

In January 2009 IES was commissioned by the West Midlands Strategic Health Authority (SHA) to develop an appropriate and innovative evaluation methodology to study and evaluate the first cohort of the programme within the West Midlands region. The primary focus of the study reported here was evaluative in the sense of seeking to identify whether or not specific hoped-for behavioural change outcomes from the development programme could be identified. However, from the outset the study also sought to contribute to the wider knowledge base of board effectiveness and engagement with clinical issues.

The Burdett Trust is a charity that offers grants to support the nursing contribution to health care. The Burdett Trust board development programme in question, designed in conjunction with The King's Fund, aims to help boards reflect on how they work together, the systems and processes they have in place to support the quality agenda, the information they receive about quality and safety, and whether good use is made of their executive nurse directors. For each participating organisation in the West Midlands cohorts, the programme activities comprised an initial diagnostic site visit to establish how the board addresses issues of quality; three board meeting observations and feedback-giving interventions (for the whole board); three coaching sessions (for the nurse executive); a £5,000 development grant (for the nurse executive); a development day (for the whole board); and a best practice and networking seminar (for all the nurse executives).

The expected outcomes from the programme included an improvement in trust boards' understanding of the patient care agenda and their involvement with clinical issues. Objectives listed for organisations in the programme were to:

- develop the leadership capacity of the nine[1] executive nurses (or equivalent job title)
- raise the commitment and engagement of their nine[2] trust boards to patient care issues, particularly through collaboration and interaction by the nurse executives with their chief executives, medical directors and chairpersons
- and thereby effect change in the way those nine[3] trust boards consider the patient care agenda and clinical engagement issues.

This report presents the findings from two on-line surveys of all executive and non-executive trust board members at nine NHS trusts and an in-depth examination of six NHS trust board meetings based on audio tapes and transcripts. The surveys and meetings took place at two different time periods as part of our evaluation study. One survey and three meetings were held between April and June 2009 *before* the delivery of the development programme in question, for nine nurse executives and their trust board colleagues. The second

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1 One nurse executive and her trust board dropped out. Eight organisations completed the development programme.

2 As above.

3 As above.

survey and remaining three meetings were held between May and July 2010, approximately three months *after* the conclusion of the development programme.

1.2 Research questions

Detailed research questions were arrived at through discussions and consultations with Sandra Gray at West Midlands SHA and David Naylor at The King's Fund during early 2009. Three research questions were identified and refined over time:

- How **rich is the dialogue about clinical issues** in boardroom conversations and is there any evidence that dialogue changes following the programme's interventions?
- How does the way a board operates influence the nature of the **conversations about clinical issues**?
- Is there any evidence of **changes in levels of clinical engagement** among the boards as a whole following participation in the development programme? Do individual members perceive they have become more 'clinically engaged'?

1.3 Context of NHS trust boards and clinical governance

Boards play a crucial role in ensuring that NHS organisations are publicly accountable and perform well. Serious questions have been raised about the ability of boards to govern effectively following various failures, eg Stafford Hospital. Such concerns have stimulated a renewed interest in organisational governance, and a growing literature on the subject (Cornforth, 2002; Storey and Holti, 2009). Some of the current literature, however, has been criticised for underestimating the constraints and conflicting demands that boards face and for recommending unrealistic solutions. For instance, Bevington et al. (2005) reviewed the recommendations for structural and procedural changes to the architecture of committees and for the kinds of skills, knowledge and experiences required to operate successfully at board level, and concluded they are not sufficient in themselves to improve the performance of boards. They argue that effective boards also need to get the balance right between board members trusting one another and constructively challenging each other if higher levels of performance are to be secured. The NHS Confederation (2005) also discusses levels of trust between board members and argues that even where there are high levels, executive (and to a lesser extent non-executive) directors fail to challenge one another. They argue that this failure to challenge is particularly true on specialist issues, especially clinical ones. Abbott et al. (2008) also found that, in general, boards appear to avoid adopting a challenging style in their relationships with officers. Nonetheless, interviews with officers and board members of three

organisations found that the possibility boards *might* challenge did affect how business is conducted, even though in reality challenge was rare.

Proactive advice abounds. For instance, the Dr Foster Intelligent Board series (2006 a, b and c, 2007) has looked at different types of trust boards and offered practical advice. Their latest report (2010) argues that patient experience is undermined at the expense of other areas (patient safety and clinical effectiveness). The authors suggest examining board focus and the difference between rhetoric and action on a specific clinical issue. The US-based Institution for Healthcare Improvement (2008) similarly offers a framework for health care improvements, including board-level initiatives such as including patient stories in board meetings and using chief financial officers to drive quality improvements.

There have been a small number of detailed empirical studies of what boards do in practice and how they take account of clinical issues. Abbott et al. (2008) conducted documentary analysis of board papers from 15 NHS organisations and showed that boards are more likely to discuss 'second order' functions (finance, governance, administration) than clinical and service issues. Mueller et al. (2004), researching within one hospital, drew on discourse theory and the literature on rhetoric to study how board members (clinical, non-clinical and non-executives) negotiate their own agendas. They also identified the need to widen the argument away from a narrow focus on finance and to look at innovation in the whole clinical process. The Burdett Trust for Nursing (2006), published an analysis of trust board meetings also demonstrating heavy focus on financial targets and other 'management' at expense of clinical quality and governance.

More recently Storey and Holti (2009) explored the various ways in which clinical executive directors and non-clinical executive directors are interpreting and responding to the extensive reforms and restructuring in the UK health service. Som (2009) also contributes to the current debate on the implementation of clinical governance by exploring the understanding of clinical governance at different levels in one NHS organisation. Using a case study method with in-depth interviews, Som shows how differently organisational actors make sense of the term 'clinical governance'.

Peck et al. (2004) examine the role of the board in the light of the literature on ritual and locate the importance of the board meeting in the formation of social solidarity. This theoretical approach highlights issues around classification and language. Peck and colleagues show how this results in some members of NHS boards feeling disempowered. They also identify the challenges in engaging a broader range of stakeholders (including patients and carers) in these rituals. Stanton (2006) provides a reminder of the importance of the leadership role of the board in fostering a positive culture of change in enthusing and empowering staff.

Other research has focused on individual roles within NHS boards and/or on the relationships between board members. It is over a decade since chief executives were given extended responsibilities to include quality and clinical governance as well as financial and managerial responsibilities. Sausman (2001) warned that they would need support to discharge these new responsibilities. Also in 2001 Exworthy and Robinson used the two theoretical perspectives of role theory and negotiated order to consider the nature of relationships between the chair and chief executive, the 'two at the top'.

McNulty and Pettigrew (2005) offer a non-NHS perspective in an examination of the contribution to strategy by chairmen and NEDs in large UK companies. The collective label of 'part-time board member' is used to refer to individuals performing these roles. Their involvement in strategy is conditioned by factors such as changing norms about corporate governance; the history and performance of the company; the process and conduct of board meetings; and informal dialogue among company directors between board meetings.

1.4 Study design and methodology

This study adds to the literature about what boards do in practice and how they take account of clinical issues. The study focused on outcomes by collecting evidence of 'what' changes (if any) in behaviour were actually made following participation in the development programme within the participating organisations, comprising five provider trusts[4] (including an ambulance trust) and four primary care trusts (PCTs).

The aim was to identify whether/which changes had occurred and what the nature of such changes appeared to be through two key approaches:

- a detailed examination of board level conversations
- exploring the views of individual board members.

1.4.1 Board conversations

We conducted a micro-practice examination of the nature and language of care-related discussions in a sample of three boards from among the participating organisations. This involved developing a new approach drawing on elements of

[4] The one provider trust which did not complete the programme did participate in the pre-programme survey. Thus pre-programme responses were received from nine organisations and post-programme responses were from eight organisations.

discursive psychology, conversation analysis and content analysis. We proposed in-depth conversation-type analyses of board meeting audio transcripts to see if the nature or language had changed over time and what this told us about clinical engagement. We adapted the theoretical and methodological approaches taken from conversation analysis and discursive psychology of the micro-practices that characterise pair processes in a work setting for use on group processes in the board meetings.

We attended and recorded six board meetings at three participating organisations. We recorded at two time points during the programme: firstly, as part of the pre-action phase of the programme at the board meeting before the first board observation visit by The King's Fund consultant; and secondly, at a board meeting between three and six months after the programme had finished to see whether there were any changes.

1.4.2 The survey

In addition, an assessment of changes in behaviour over time was made at the reporting level of all board members in all nine organisations combined. We gathered perceptual data measuring the levels of commitment and clinical engagement of all board members in all nine of the original participating organisations using a structured questionnaire survey.

We administered two surveys on-line via email link direct to the IES website. We conducted the surveys at two time points during the programme: firstly, as part of the pre-action phase of the programme before the first board observation visit by The King's Fund consultant; and secondly, three to six months after the programme had finished to see whether there were any changes that had been sustained for several months.

The details of the two approaches will be discussed in the following sections.

1.4.3 Board talk: pre- and post-programme analysis of quality of care conversations in NHS trust board meetings

Background

Conversation analysis is an intensive, qualitative, in-depth, systematic, comparative and inductive micro examination of real-life interactions. The analysis uses audio or video recordings to explore the patterns, structures and practices of everyday informal conversations as well as those taking place in formal institutionalised settings. It looks at the order and organisation of how people contribute, as well as how they respond to each other's contributions

within an interactive setting, and what they achieve in the course of doing so (eg offers, requests, invitations, complaints and agreements).

Conversation analysis is not an interpretative method and so it does not rely on assumptions of how people think or what motivates them. It also does not aim to uncover people's hidden motives or beliefs. It focuses on what actually takes place during authentic interactions. Because of that, conversation analysis has the advantage of not relying on people's retrospective accounts of what happened, which can be liable to memory gaps as well as biases.

The origins of conversation analysis can be traced to ethno methodology and the work of Harvey Sacks and colleagues during the 1960s. Conversation analysis is most commonly used to analyse similarities over time in interactions between two individuals. The use of conversation analysis in studies looking for changes over time or within groups in organisational settings is not totally without precedent. Samra-Fredricks (2002) observed directors and senior managers in the boardroom and in top management team meetings in a talk-based study about how skills, knowledge or know-how and experience are deployed to influence boardroom process. Clifton (2009) published results from a study of influence and decision-making within management team meetings. Using conversational analysis as a methodology and videotaped data, he provides a micro-analysis of how subordinates as well as superiors can influence decision-making episodes of talk. Since 2006 Clifton has argued that conversation analysis is able to make explicit the normally 'seen but unnoticed machinery of talk with which leadership is enacted'. He argues that the results of such a detailed research method can give researchers a clearer insight into the leadership phenomenon and is therefore eminently suitable for feeding back to practitioners to help improve leadership, communication and decision-making practices.

Setting up

The three sample organisations were selected by West Midlands SHA client in consultation with IES to represent diversity in terms of:

- organisation type – one acute, one PCT, one ambulance
- experience of nurse executive – newly appointed to long serving
- size of board – numbers attending board meetings spanned a 10–22 range.

Our approach was to contact the three relevant nurse executives and ask for their support in making this happen with the minimum of fuss and disruption to their board member colleagues. We provided each with additional background information and a copy of the consent forms we planned (with their permission) to distribute to board meeting attendees. It highlighted our commitment to protect

the anonymity of both the individual members and the trust itself and clarified that IES will not publish the names of which trusts were kind enough to let us visit.

We asked the nurse executives to give us the date and details of the next board meeting convenient to them, to secure an official 'invitation' for IES researchers to record the meeting and to let their colleagues know it was happening. We also asked for a second date to return after the programme had finished.

IES posted an information sheet to all expected attendees at the three board meetings, asking them to return a consent form to us in a reply-paid envelope (we also took copies on the day in case any more were needed by members of the public or press attending). A copy of the information sheet can be seen as Appendix 3. A full set of consent form permissions from expected board attendees was received from all three sites in advance of the board meetings. All three selected sites were most helpful in facilitating our access.

The first time-period set of audio recordings took place successfully during summer 2009. All three were in advance of the first observational visit by The King's Fund consultant, although preliminary 'contracting' discussions with the CEO and chair had already taken place. The second time-period set of recordings took place during summer 2010.

How IES has applied conversation analysis

Through conversation-style analysis we can examine how the wider institutional structure of meetings influences the way that issues are raised, discussed and managed by participants and how speakers manage their contributions.

We examine, in particular, how each member acts to fulfil the aims of their institutional identity (chair, non-executive, executive). We focus on the nurse executive whose aim is to bring the 'ward into the board' and enable the trust to engage more effectively with patient care-related issues.

The process of using this analysis is as follows:

- Two researchers attend a board meeting in an observational capacity. Their role, as non-participant observers, includes setting up the audio equipment; securing consensus from all participants that they are informed and happy to have their meeting recorded; creating a seating plan of the members in attendance and their roles; collecting reports relevant to the meeting; tracking the flow of the conversation so once transcribed, each utterance can be attributed to the right speaker; and making notes about important non-verbal behaviour.

- At the start of the meeting the researchers begin the audio recorder and a stop watch simultaneously. A total of 750 minutes of discussion were recorded across the six board meetings. It is worth noting that there are many speakers participating in these board meetings (there were between 10 and 16 for those we recorded). It is therefore important to track the order in which speakers are taking part. We record the turns in conversation by using a specially designed tracking form, which tracks every utterance made throughout the meeting, patterns of turn taking, overlapping conversation and interruptions. It also allows the time on the stopwatch to be recorded at regular intervals and key words to be noted.
- Subsequently, these audio recordings are transcribed in full to include, where possible, signs of hesitation and the actual timing of each turn in conversation.
- Using the full transcriptions along with the tracking sheets, we can attribute the institutional identity of each speaker to their respective turn.
- Based upon the research question, criteria are then developed to determine what extracts of the transcripts will be subjected to conversation analysis. The recordings of the trusts generated a large body of data. Conversation analysis is time-consuming and needs patience and care in analysis. Selection of sequences for conversation analysis has to be highly focused.
- Two researchers then undertake the analysis by firstly numbering each line of speech in an extract and then working through line-by-line and noting the discursive tools used, how each turn is structured, the effect it has on the rest of the board, how participants are interacting with one another, whether there are indications of agreement or disagreement, whether the utterance is commencing a new subject or closing another, and so on.
- In addition to looking at language, we also take into account the time dedicated to each item in the agenda.
- We use 'word clouds' to illustrate the frequency with which words are used during the course of the meeting, excluding common English words such as 'the' and 'to' *etc.* Word clouds give a visual representation of the time devoted to specific issues in the meeting.
- The researchers also undertake an analysis of roles played in the meetings by participants using two further methods. Firstly, they look at how long each participant spoke at the meeting in order to assess how much influence they potentially had. They then look at how participants interacted with one another by tracking the turns taken in the interactions. This provides an indication of the effectiveness with which each participant can fulfil their role and share their

views within the meetings. It can also reflect participants' levels of interest in the topics raised by others.

Limitations of the conversation-style methodology

It is worth highlighting some limitations of the methodology which need to be taken into account.

- The meetings were audio recorded and supplemented with manual tracking by two recorders to identify the speakers. Where there were rapid interactions it was sometimes difficult to accurately follow who was speaking.
- An alternative would be to video the meeting, which would have provided a completely accurate record but may have been more intrusive and may have influenced the proceedings to a greater extent.
- In an ideal evaluation the individuals attending the board meetings would have been the same both before and after the programme but inevitably there were some changes of personnel and absences. This may have influenced the dynamics of the discussions but the extent of this cannot be assessed.
- Additionally, the agenda items for the meetings, although under the same general headings, had different emphases, which may have provided different opportunities for clinical engagement.

One specific practical difficulty we encountered was a failure of the recording equipment over half-way through one of the post-programme board meetings. The failure was not detected until the end of the meeting, which meant that the back-up equipment on-site was not put into use. We did consider collecting data from a future board meeting instead but that would have been outside our agreed time parameters for data collection of three–six months after the programme finished. As a result we have not included this trust in some of our pre- and post-programme analyses (eg words used in board conversations and time spent on clinical board agenda items, reported in Chapters 2 and 3). However, we have been able to select some good conversation-style analysis examples from this trust.

1.4.4 Perceptions of clinical engagement: pre- and post-programme on-line surveys of NHS trust board members

Defining 'clinical engagement'

A key part of the initial phase of our research was to define clinical engagement in order to identify the types of behaviour and conversations that are relevant to an awareness of patient issues at board level. IES conducted a literature review to find a widely-accepted definition. It became apparent that there is no one clear

meaning. One thread finds clinical engagement generally taken to mean the involvement of clinicians in the decisions concerning how health services are to be developed and delivered. This has a different emphasis to that of the current study, which focuses on the consideration of patient health and safety at board level, in turn reflecting the engagement of all board members.

The existing engagement literature from IES and elsewhere was reviewed to understand the general background to engagement. The intention was to build on the existing work on engagement and to identify if any useful instruments existed that would prove a starting point for the current evaluation. A bibliography of the reports and articles used can be seen in Appendix 1.

From the literature on engagement it was clear that there were numerous and often inconsistent definitions, depending on whether it was being viewed from an organisational, academic or consultancy point of view. Engagement was variously seen as a psychological state, a performance construct, an affective state or an attitude. These varying definitions led to different indicators being created to measure each form of engagement. In addition, the review of the literature confirmed that these engagement concepts were largely concerned with employees' attachment and commitment to their organisation. However, within the context of this study the focus is not on engagement towards the organisation, but specifically to clinical issues, and therefore it was apparent that *clinical* engagement had to be considered as a quite separate concept.

The report entitled 'From Ward to Board' (Machell et al., 2009) reports on the first national cohort of the Burdett Trust and King's Fund programme and was the most useful document identified in the literature searches. This does not directly define clinical engagement but the report makes clear that it is the engagement of NHS boards with *clinical quality* concerning the quality and safety of patient care that was relevant to this evaluation. The clinical engagement of the board will ensure that the 'quality of clinical care is at the heart of the organisation's business' and it is this interpretation that we seek to measure through the programme evaluation.

The Machell report is concerned with how to create clinical engagement at board level and identifies a range of 'lessons learnt' which can be used to assess the levels of engagement among trust boards:

- having the right processes in place and the right relationships for continuous quality improvement
- making it explicit that clinical quality is an issue for the whole board
- having information available about clinical issues

- valuing and acting on intelligence on the patient experience, both negative and positive
- demonstrating openness and transparency in board meetings
- having NEDs who can constructively challenge executive colleagues.

These features provided the criteria for assessing the clinical engagement of the trust boards which we have used throughout our evaluation research.

Design of survey instruments

The questionnaire was created with the purpose of measuring clinical engagement within the board and identifying what the impact of the programme had been on the board and role of the nurse executive in supporting the impact this. In considering the definition of clinical issues it was concluded that the perceived attitude of boards to matters around patient safety and care should be the focus.

In the absence of an existing measure of clinical engagement it was necessary to take steps to create such an indicator. A number of items were included in the questionnaires which were considered to cover the key aspects from the Machell report, as shown in the preceding section. Questions were also added to ensure that other potentially relevant aspects of clinical engagement were not overlooked. In this way we could explore the differences in clinical engagement between trusts and track how it changes during the programme.

The final pre-programme questionnaire contains questions on the profile of the respondent, covering their role on the board, gender, experience of the NHS and their views of the Burdett Trust/King's Fund programme. The remainder of the questionnaire was composed of a number of statements. Respondents were asked to state their reactions to the statements using a five-point Likert scale ranging from 'strongly disagree' to 'strongly agree'.

The following topics were covered:

- patient care
- patient safety
- the role of the nurse director
- the working of the board
- communication and the board.

Due to the extremely tight project timescale for launching the pre-programme questionnaire (two weeks) we used a shortened pilot relying on detailed feedback from: two West Midlands SHA representatives; two NEDs, one from a mental

health trust background and one from an acute trust; and two occupational psychologists and social science researcher peer reviewers. As a result of their feedback some tweaks were made to the language (eg NEDs found 'nurse director' more meaningful than 'nurse executive') and signposting of the questionnaire. The final version of the questionnaire was approved for use by West Midlands SHA on 7 April 2009.

As a result of feedback received from the pre-programme survey as well as further consultation with the nurse executives and a small pilot with a few board members, the survey was further developed for use post-programme as follows:

- Feedback received from the pre-programme survey indicated that several items within the survey may not be applicable to PCT respondents, and therefore changes were made to a number of selected items.
- In order to create a survey that would be applicable to a PCT and trust audience, it was decided that two separate surveys would be more appropriate, with the majority of items consistent but with some differences.

Survey distribution, collection and analysis

The pre-programme survey was 'live' on the IES website between 8 April and 29 May 2009. A link to the pre-programme survey was distributed by email to 138 board members on 8 April 2009 using email addresses supplied by West Midlands SHA. Two paper copies were posted to NEDs who preferred hard copy. One email reminder was sent on 29 April 2009. A total of 71 responses were received. This represented a response rate of slightly over 50 per cent.

The two post-programme surveys (one for provider trusts, one for PCTs) went live on 3 September 2010 and were available for completion until 1 October 2010. Two email reminders were sent from the SHA. A total of 33 responses were received across the two post-programme surveys. This represented a response rate of 30 per cent.

The survey data was analysed using the Statistical Package for the Social Sciences (SPSS). The results of this analysis are presented later in the report. Due to the relatively small number of respondents to the pre-and post-programme surveys, advanced statistical analysis was not possible. However, demographic information on the respondents and mean average responses are shown in this report. A breakdown of the answers to each item on a Likert scale of strongly disagree to strongly agree can be seen in Appendix 2 . The results of the pre- and post-programme surveys are compared where possible (ie where the item was presented in both the pre- and post-programme surveys or where the survey item had not been modified to the extent that the context/content was changed and

therefore would continue to allow meaningful comparison) to identify any changes in mean scores on survey items.

Advantages and limitations of our on-line survey approach

We decided to undertake an online rather than paper-based survey due to the benefits of, and our extensive experience in using, this method of data collection. We hosted the survey online on our website and were therefore able to individually email the link to the survey sample and personalise it. We were able to tag each invitation to participate with a unique number to track and avoid duplications. In addition, as a result of hosting the survey on our website, there were fewer data security concerns to overcome. An additional benefit of online surveys is that data submitted is automatically transferred into an excel database ready for analysis, which avoids time-consuming manual data entry and the higher risk of human error.

Despite the advantages of online surveys, there are still several limitations in the use of the method which must also be acknowledged. For instance, email and online surveys can present a selection bias (ie people without email or computer access will be unable to respond). In addition, given the rise in online surveys over recent years, people may experience survey fatigue and therefore a reluctance to complete an online survey.

As we have noted, the pre-programme survey instrument itself worked well for commissioned services and provider trusts but it transpired that some of the questions were very hard for PCT respondents to answer. For example, asking how the board sees information on quality data led to different interpretations depending on whether respondents considered it to refer to commissioned services or the in-house provider.

As a result, board members from the four participating PCTs may have interpreted the questions differently. One PCT CEO took a proactive approach in asking all her board members to assume that they were responding as a commissioner, ie the questions are about the providers they commission services from and they should respond as a commissioning PCT. However, individual respondents elsewhere may not have done this. As a result we have not reported on responses from PCTs to some of the items in question.

With the assistance of two participating nurse executives, the questions which were ambiguous or inappropriate for PCT respondents were identified and re-worked for the post-programme survey and subject to a longer and thorough piloting process. We also included some additional questions relevant to the emerging role of the commissioning-only PCT, which are reported later as a snapshot view.

It should be noted that the response rate to the second survey (30 per cent) was considerably lower than to the first (50 per cent). A number of possible reasons for this have been suggested by the board members we asked, but principally it is general survey fatigue. Other reasons we were told include the fact that the timing of second survey in 2010 was shortly after the coalition government was formed, when rumours of spending cuts and reorganisation were absorbing board members' attention; completion of the first survey was seen to be strongly endorsed by SHA chair and trust chairs, leading to more responses to the first survey than we might normally have expected; and over time nurse executives got more confident in telling their board colleagues how things really were and some (non-)executives may have been reluctant to identify the environment as more difficult than a year before.

1.4.5 Post-programme telephone discussions with executive nurses

The first draft of this final evaluation report, including conclusions, was completed in December 2010 and presented to the West Midlands SHA study commissioners. During March 2011 we held telephone discussions with two SHA representatives, three executive nurses and the Burdett Trust programme leader from The King's Fund. These discussions focused primarily on the implications of the evaluation study for practice, especially within the context of the forthcoming 'new NHS' of GP commissioning consortia and cluster boards.

1.5 Purpose and structure of this report

IES has produced this report for the West Midlands SHA, who financed the development programme, and for the Burdett Trust for Nursing, who co-financed the evaluation study, to present the findings of our evaluation. It is the final report of the evaluation study following two unpublished interim reports (Carter et al., 2009 and Hayday et al., 2010).

The final report is also intended for publication and dissemination to a wider audience of policy-makers and NHS practitioners as a contribution to the evidence base on clinical engagement, governance and leadership. In order to realise benefits for patients from the current quality-of-care initiatives, it is essential that boards operate effectively. Those who wish to gain a deeper understanding of how NHS boards engage with issues and make decisions may also find this report of great interest.

The remainder of the report is structured as follows:

Chapters 2–6 present the findings of our various analyses of the six trust board meetings we recorded and transcribed. The chapters comprise the words most often used during the meetings, including patient-related words (Chapter 2); the

time allocated within the meetings to patient-related matters (Chapter 3); sequences from board meeting transcripts demonstrating how the boards engaged with clinical issues shortly before their exposure to the Burdett development programme and which highlight how meeting processes can constrain members from discussing and getting involved with the patient care and safety agenda (Chapter 4); sequences from board meeting transcripts held after the programme demonstrating a range of interactional activities that enriched the dialogue on care and patient safety (Chapter 5); and the contribution of board members to the meetings and how they interact with each other (Chapter 6).

Chapters 7–8 present the findings of our analysis of the on-line surveys we conducted with the executive and non-executives directors from all the boards participating in the programme. Chapter 7 introduces the surveys, outlines the respondent profile and presents board members' expectations of the Burdett Trust programme. The views of board members on a range of clinical engagement items are presented in Chapter 8, including a comparison of their perceptions before and after exposure to the development programme on issues including care quality, patient safety, the role of their nurse executive, the workings of their board and communications on their board.

Conclusions of our study are presented in Chapter 9, where we also discuss the implications for practice (especially in the context of the 'new NHS') and the implications for research into patient quality, safety and experience, methods for leadership research and research into board development.

Appendices 1–3 may be of interest mainly to researchers as they contain a bibliography (Appendix 1), more detailed survey response tables (Appendix 2), and the information sheet and consent form issued before conducting board meeting recordings (Appendix 3).

2 Words Used by Board Members

2.1 Introduction

This chapter is the first of five in which we present analyses of the 750 hours of recordings and transcripts from the six board meetings. Our overall aim was to identify any changes in the way clinical, quality and other patient care-related issues are talked about by board members. This particular chapter presents a series of 'word clouds[5]', which are simply a count of the number of times each word is said during each of four out of the six trust board meetings and then representing this in a diagrammatic form. The bigger the word in the diagram, the more times it was said during the meeting. Each cloud is examined independently and comparisons are also made between them. Each 'word cloud' excludes common English words such as 'the', 'to' *etc.* as well as any identifying information such as names and places. Although more commonly seen in the populist press than academic circles, we have opted to use word clouds as we believe they are a useful and accessible presentational tool. We have opted to present word frequencies for four out of the six board meetings as these four cover the two trust boards (Trusts 1 and 3) for which we have complete pre- and post-programme transcripts.

Each meeting was different in terms of the precise agenda, length of meeting and number of people attending. Inevitably this will have affected the words spoken (and these issues are discussed in more detail in subsequent chapters), so caution is needed when looking at the comparisons. However, since each meeting dealt with a range of issues, including budgets and patient safety, we believe this is a useful introductory perspective to our analyses of the transcriptions. The main differences between the board meetings were actually wider contextual factors

[5] Word clouds presentation tool by Jonathan Feinberg, (2009), www.wordle.net

affecting both trusts. The pre-programme meetings were recorded during the preparations for the Swine Flu pandemic. The post-programme meetings were recorded after the May 2010 general election amid speculation about reorganisation and efficiency savings.

2.2 Trust 1: pre- and post-programme

Figure 2.1 shows the top 100 words used during the course of the entire pre-programme board interaction, inclusive of all members involved in the meeting.

Figure 2.1: The top 100 words used by the entire Trust 1 board: pre-programme

Source: IES, 2009

'Year' is the most frequently used noun throughout the course of the board meeting. This often refers to past and future years and occurs approximately 108 times throughout the meeting.

Perhaps to be expected, given the nature of board meetings, the term 'report' is often used (on 97 occasions) to reflect the reporting back on reports and papers and the reports themselves (see Table 2.1). The board itself is also often referred to (68 occasions).

The terms 'commissioning' and 'strategy' are frequently used in the meeting, over 60 times each, and terms relating to finance, including 'finance', 'money' and 'costs', are all used more frequently throughout the course of the meeting than terms relating to patient care, such as 'clinical', 'safety' and 'patient', ranging from

24 to 47 occasions and 6 to 15 occasions respectively. This would seem to support the literature on boards described previously in which it has been suggested that there is greater discussion of finance issues compared with clinical issues (Burdett Trust, 2006).

'Quality' appears on 48 occasions and often relates to the Quality Standards Committee, the Care Quality Commission, monitoring quality and the quality agenda. There are also some references to the quality of services and patient care.

Figure 2.2 shows the top 100 words used during the course of the entire post-programme board interaction, inclusive of all members involved in the meeting.

Figure 2.2: The top 100 words used by the entire Trust 1 board: post-programme

Source: IES, 2010

'People' is the most frequently used noun throughout the board meeting. This often refers to board members, eg *'any comments or feedback that people have got'*, the general public, eg *'asking people their opinions'*, staff, eg *'a change in people's employment'* and service users, eg *'some of the people, a significant cohort of patients'*.

Unsurprisingly, again, given the nature of board meetings, the term 'report' is often used to reflect the reporting back on reports and papers and the reports themselves.

Also noteworthy is the frequency with which indications of agreement are used, for instance, 'yes' appears in the top ten most common words used, used on 48 occasions, while 'no' is only used on 12 occasions.

The fourth most common term used is 'patient', used on 57 occasions. This is often used in reference to patient care, such as moving patients across NHS sites, outpatients, asylum seekers/migrants, cardiac patients, patient consultations, patient needs and appeals processes, the patient experience, GP patient registration and referrals, and patients' rights. On one occasion it directly relates to patient safety. The term 'safety' is used on three occasions over the course of the meeting. On one occasion this relates to quality and safety standards. 'Quality' is used 21 times. This is also often used in reference to the quality of patient care (for example, stroke care, nursing, primary care and PALS) and the quality of life of patients. It also relates to the Quality and Safety Standards Committee quality policies and indicators, such as the quality dashboard. In addition there is reference to the quality of board papers and the quality of staff.

Table 2.1 compares the numbers of times words are used in the pre- and post-programme meetings, and shows which have gone up and which have gone down.

Table 2.1: Frequency and ranking of key terms used: Trust 1

Term	Frequency of use/ranking 2009	Frequency of use/ranking 2010	Rise and fall in ranking
Year	108 (1)	63 (2)	↓
Report	97 (2)	59 (3)	↓
Work	82 (3)	0	↓
Board	68 (4)	0	↓
Commissioning	64 (5)	0	↓
People	62 (6)	75 (1)	↑
Issues	61 (7)	50 (8)	↓
Strategy	61 (7)	12 (38)	↓
Health	59 (8)	0	↓
More	51 (9)	0	↓
PCT	49 (10)	55 (6)	↑
Quality	48 (11)	21 (29)	↓
Finance	47 (12)	16 (34)	↓
Costs	37 (14)	2 (48)	↓
Yes	25 (20)	48 (9)	↑
Money	24 (21)	24 (21)	nc
Patient	15 (29)	57 (4)	↑
No	14 (30)	12 (38)	↓
Clinical	8 (36)	15 (35)	↑
Safety	6 (38)	3 (47)	↓

Term	Frequency of use/ranking 2009	Frequency of use/ranking 2010	Rise and fall in ranking
Question	0	54 (7)	↑
Organisation	0	56 (5)	↑

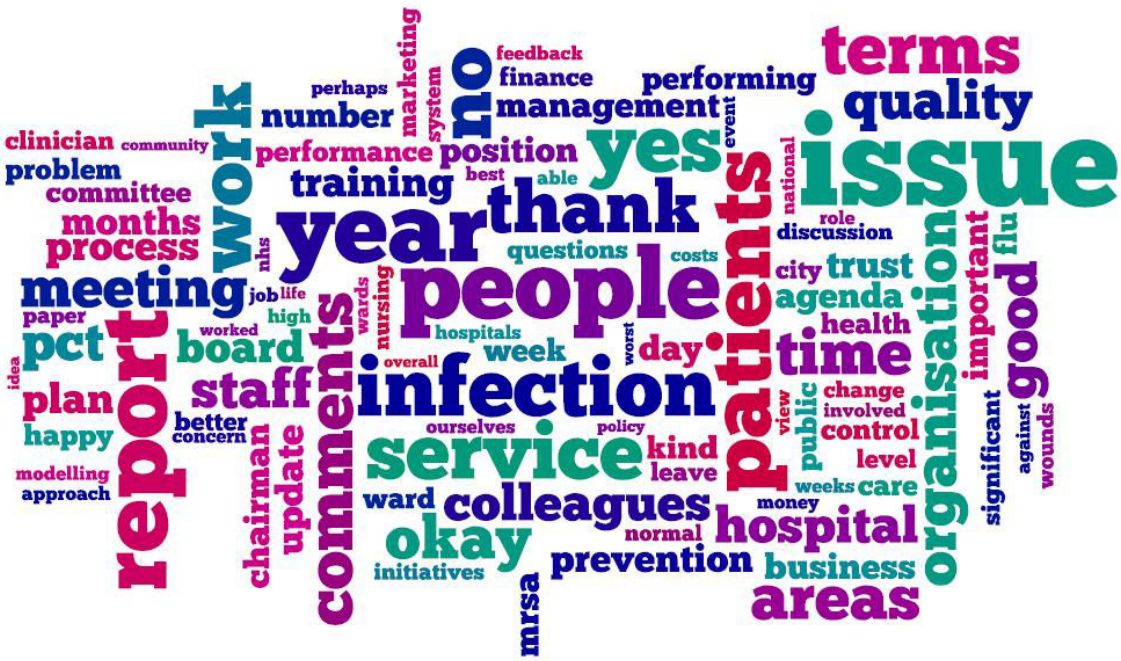
Source: IES, 2010

The word clouds presented from Trust 1, pre- and post-programme, indicate a shift in the emphasis of the discussion that took place during the two board meetings. The pre-programme word cloud shows that terms relating to commissioning, strategy and finance were more commonly used than those relating to clinical issues. However, the post-programme word cloud indicates that the use of terms is more balanced, with strategy, finance and commissioning referred to with generally less frequency than in the pre-programme meeting, and terms relating to clinical issues, quality and patients showing greater prominence in the word cloud.

2.3 Trust 3: pre- and post-programme

Figure 2.3 shows the top 100 words used during the pre-programme board meeting, inclusive of all those who participated in the meeting.

Figure 2.3: The top 100 words used by the entire Trust 3 board: pre-programme



Source: IES, 2009

The top five most common nouns (excluding common English words) are 'issue', 'people', 'year', 'report' and 'patients'.

Figure 2.4 shows the top 100 words used during the course of the entire board interaction after the development programme, inclusive of all members involved in the meeting.

Figure 2.4: The top 100 words used by the entire Trust 3 board: post-programme

Source: IES, 2010

The top five most commonly occurring nouns are 'board', 'services', theatres', 'year' and 'health'. Note also the increased prominence of 'patients' in the word cloud, where there has been an increase from 27 instances in the pre-programme meeting to 37 post-programme. Indicators of agreement and disagreement have also notably risen since the pre-programme meetings (yes: 26 pre-programme, 59 post-programme; no: 24 pre-programme, 63 post-programme).

2.4 Relative contributions of board members

Word counts of Top 100 words were also identified for each of four key players on the board at both trusts: nurse executive, medical director, chief executive and chair. As results were similar, we present the findings from one trust:

- The nurse executive in the first board meeting is the one who talks the most about 'complaints' and 'patients' (both used on five occasions each).

- Relative to other members of the board, the medical director contributes much less to the meeting both pre- and post-programme. Several of the terms used by the medical director relate to financial and strategy matters, such as 'reinvest', 'finance', 'competitive' and 'review', with no use of the terms 'quality', 'patients' or 'safety' in the top 100 word used in the pre-programme meeting. 'Consultant' is one of the most commonly used terms by the medical director, often in the context of consultant absence. In comparison with the pre-programme meeting, the medical director uses slightly more terms that make reference to patients and services such as 'patient', 'theatres' and 'anaesthetists'.
- The chief executive frequently uses the term 'people' – 16 times at each meeting – in reference to NHS staff and patients. 'Services' (13 mentions) also feature as does 'no' (19 mentions). This suggestion of disagreement is more prevalent post-programme than pre-programme. However, the term seems to be used less as an indicator of disagreement and more in relation to 'being no further (in terms of progress with an investigation)' and having 'no doubts' about organising the number of services across as area.

  As perhaps could be expected, the chair of the board often uses terms which show appreciation and reflect a desire to move the agenda along, as is their role, such as 'thank', 'okay', 'good' and 'move'. These terms often occur in the closing of a discussion and moving onto to the next item on the agenda, eg *'Okay. Move on to the Infection Prevention.'*
- There is reference to 'report', a term used on eight occasions and 'agenda', a term used on five occasions. The chair uses terms that reflect their role as facilitator of the meeting and to draw the attention of the board to specific items and papers, ie using terms such as 'page', 'point', 'report' and 'minutes' as well as 'okay' and 'right', the latter often indicating movement to a new issue or to clarify the accuracy of a claim or remark, eg *'Right shall we move on to part 2 of our meeting?'*

2.5 Chapter summary

There are three key findings arising from our word cloud analysis of Trusts 1 and 3 pre- and post-programme:

- Emphasis shifts from terms relating to commissioning, strategy and finance to those relating to clinical issues, pre- to post-programme.

The word clouds presented from Trust 1, pre- and post-programme, indicate a shift in the emphasis of the discussion that took place during the two board meetings. The pre-programme word cloud shows that terms relating to

commissioning, strategy and finance were more commonly used than those relating to clinical issues. Clinical terms are more prevalent post-programme.

- The nurse executive uses the most patient care-related words.

The nurse executive uses more terms pertaining to clinical issues than any of the other three board members in Trust 3, both pre- and post-programme.

- The chair uses words which structure and move the meeting forward.

Self-expectations of the role of the chair are highlighted in the frequency with which the chair uses specific words. For instance, the chair in Trust 3, both pre-and post-programme, often uses terms which reflect an intention to move the agenda along, or to close or open a discussion, reflecting a perception of the role as one of facilitating, structuring and leading the discussion.

In the next chapter we examine the time allocated within the board meetings to patient-related matters.

3 Time Dedicated to Patient Care Issues on Board Meeting Agendas

This chapter is the second of five presenting the findings from the conversation analysis of the transcripts of the six board meetings. In this chapter we examine the time dedicated to each item on the board meeting agendas and its order of presentation within the agenda. We show how the structure of the board meetings changed between the pre- and post-programme phases regarding the time and order dedicated to discussing quality of care and patient safety.

The board meetings that we observed dealt with each item in a particular order; this was set by the agenda, which also stated the structure, person to raise each item and an estimated time to be dedicated to each item. This means that turns in speech were pre-allocated to a certain extent, allowing for other speakers to interrogate and comment. The purpose of raising each item also differed; some items were to be raised to gain the board's approval on a particular subject, while others were there for members 'to note'.

Although we do not have full transcripts for all six meetings, we do have a full set of detailed researcher notes including timings. Thus all six meetings were available for analysis on this issue.

For both Trusts 1 and 2, the same stark differences were apparent between their pre-and post-programme meetings. These were:

- Items on quality and patient safety were not introduced until two and a half hours into the pre-programme meeting. In the meeting after the programme had been completed, these items were taken up and discussed half an hour in. In fact, in the post-programme meeting quality and patient safety were introduced as soon as opening statements and the chair's update were completed.

- In the post-programme meeting, board members spent 45 per cent of their time debating quality and patient safety issues whereas in the pre-programme meeting they had spent only 10 per cent of their time doing so (see Table 3.1 for Trust 2).

Table 3.1: Time spent on agenda items, Trust 2

Items in the agenda*	Pre-programme meeting (min)	Pre-programme meeting (%)	Post-programme meeting (min)	Post-programme meeting (%)
Opening statements**	11	7	14	16
Chair update	5	3	3	4
Governance & strategy	126	80	30	35
Quality & patient safety	16	10	38	45
Total	158	100	85	100

Notes: *Includes only items of business for which the press and public may be present. **Includes welcome, apologies, declarations of interest, questions from the public.

Source: IES, 2009 & 2010

This comparison between the two board meetings illustrates how dealing with quality and patient safety items early on in the meeting encourages board members to engage more with these issues and to discuss these for longer. On the other hand, delaying the introduction of these items may result in less interrogation and debate as it increases the risk of members' fatigue and time pressures to 'finish on time'. For example, in the pre-programme meeting, the quality and patient safety items were introduced at the end of the board meeting (the section open to the public and the press), amidst the chair's reminders of the imminent lunch break.

Trust 3 on the other hand (see Table 3.2) also spent more time on quality and safety issues after they completed the programme. However, Trust 3 spent less time proportionally on the quality of care and patient safety agenda after the programme. This is because of a much longer post-programme board meeting in which the board's engagement with all the issues was far more serious and they did, we report later, also tackle quality of care issues in more depth.

Table 3.2: Time spent on agenda items, Trust 3

Items on the agenda	Pre-programme meeting (mins)	Pre-programme meeting (%)	Post-programme meeting (mins)	Post programme meeting (%)
Opening	5	5	9	5
Operational performance	5	5	21	12
Business planning	23	25	49	28
Quality & safety	17	19	27	16
Finance	6	7	3	2
Governance & strategy	16	18	41	24
Other business	19	21	23	13
Total	91	100	173	100

Source: IES, 2009 & 2010

In a later chapter we will explore how the differences in time spent may have impacted on the nature of the discussions.

In the two next chapters we will look at the language used in the board meetings. We present sequences from the transcripts together with our analysis of how patient-related issues and quality of care were discussed.

4 Boardroom Conversations Before the Programme

In this chapter we present the first four of nine sequences from board meeting transcripts followed by our analysis of what was happening. Each sequence starts with the chair's invitation for a particular item in the agenda to be raised and ends with the chair terminating discussions on an item and inviting a speaker to raise a new one.

4.1 Board talk in context

Through in-depth analysis of turns in conversation between the nurse executive and the other members of the board we examine the particular institutional rules and patterns of 'doing board talk' along the lines of which the nurse executive interacts with other members and the extent to which these patterns allow for clinical issues to be brought into the boardroom. At the same time, we recognise that each member acts to fulfil the aims of their institutional identity (chair, non-executive, executive). The nurse executive role, in particular, aims to bring the 'ward into the board' and to enable the trust to engage more effectively with patient care-related issues.

Since conversation analysis is used here in the context of evaluating a development programme, it is tempting to use this approach in order to evaluate progress in the communicative abilities of specific individuals, particularly of those holding key roles such as the chair, the chief executive or the nurse executive. However, such a focus would disregard the preoccupation of conversation analysis with the 'normative character of paired actions: a first speaker's production of the first pair projects a slot into which the second speaker should produce the appropriate second part' (Wooffit, 2001; p. 53). In other words, trust board members' individual contributions to discussions about clinical issues are tied up with those of their co-discussants and with the institutionally acceptable ways of conducting such discussions. The analysis and its results

should not therefore be limited to an evaluation of individual contributions/utterances.

The sequences from pre-programme board meetings are chosen in order to analyse how the board engaged with clinical issues shortly before their exposure to the Burdett development programme; effectively they were selected to highlight institutional rules of conducting board meetings that constrained members from discussing and getting involved with the patient care and safety agenda, prior to training. Having read the transcripts of the post-programme board meeting recordings many times over, sequences were identified whereby trust board members demonstrated a range of interactional activities (requesting and offering assurances, probing into complaints, pitching to develop clinical services) that enriched the dialogue on care and patient safety.

The analysis of each sequence is guided by the following questions:

- How is an item in the agenda raised in the boardroom, and which aspects of it are made salient?
- What are the other members' reactions after raising an item, specifically, how do executives and non executives request further clarifications, probe, challenge, or offer new information?
- How are institutional identities constructed, expertise deployed and accountability managed in the course of these interactions?
- Finally, what are the implications of these discursive practices (raising an item, further probing, challenging, attributing blame, and so on) for the way clinical, quality and other patient care-related issues are discussed (or not) in the boardroom and for the decisions made to take further actions on these issues?

We first look at interactions around a 'non-clinical' issue, focusing specifically on who is speaking and what it says about their relationships (Sequence A – see Table 4.1). There is no involvement of the nurse executive in this sequence. We then move to an issue that is raised as non-clinical, yet after further requests for clarification, some clinical issues are raised by the nurse executive (Sequence B – see Table 4.2 etc). In the third sequence, the nurse executive raises some serious clinical issues (Sequence C). Sequences A to C come from the pre-programme meeting of Trust 2. The fourth sequence (Sequence D) comes from the pre-programme meeting of Trust 3, where the debate concerns a new treatment with impressive patient outcomes.

4.2 How the focus shifts from clinical to operational implications (Sequence A)

Sequence A is a typical sequence in the way that exchanges were structured around one topic in the agenda. The chair would close one topic and after a short pause would introduce a new one. The chair would open the discussion on a topic by reference to its number in the agenda – a four-page document circulated to all members beforehand – and by requesting the person cited in the agenda to raise the topic. In this particular sequence, the item for discussion was titled as 'Information Management and Technology' and was the sixth item under 'Governance items'. Sequence A took place almost an hour and a half into the meeting. Other than the chair (CH), those participating in the discussion included a representative from Information Management and Technology (IT), the medical director (MD), the chief operating officer (COO), and two non-executives (NX1 and NX3).

Table 4.1: Sequence A: Shifting the focus from clinical to operational, Trust 2

No.	Participant	Comment
1	CH	Okay, thank you very much. Can the board approve those changes? Thanks very much. Right we move on then to agenda item 6.6. Apologies (names director of Information Management and Technology) can't be with us today but (names replacement – IT) is here. (addresses IT) do you want to say anything?
2	IT	Thank you. As presented, update on (unclear) during April and May within the directorate. Then an update, (names director of it) presented this timeline before when a number of projects are coming on stream throughout the year. So this is an updated version and our plan would be to keep providing this update so you can see how we're progressing through this year on our projects.
3	CH	Thanks (names IT). Any points on (names IT)'s report? Are you happy with that?
4	MD	Mr Chairman?
5	CH	Yes?
6	MD	I think it's worth reporting some minor hiccups, could best describe it, in terms of the electronic care record over the last few days, particularly in terms of tablet to tablet transmission of data. The move forward has been agreed on the basis that it be kept under review basically, over coming weeks. It is an area we're going to have to keep a close eye on from a clinical point of view.
7	CH	(names NX3)?
8	NX3	I mean I suppose the question is why? There's various references within the overall board papers to the fact that it has had a negative impact on them back in (names two counties) in two minutes. We know it's had a very heavy training requirement in (names the two counties). Had we built all that in to our plans for the future for its roll out and where are we getting to? Because I think there's enough negatives have come back. I know that all the principles are all right and the benefits you get out of it are brilliant but one

No.	Participant	Comment
		is concerned that everybody has certain cautions about it and it's been hard to implement. It's an operational question. They're the guys who have to be happy about it; equally IT are delivering something that they're not entirely and definitely in control of.
9	COO	I think it's fair to say that delivery or additional delivery of any training has an impact on operational delivery and knowing about that training in advance, you can't really prepare in order to minimise it. In terms of the delayed turnaround, I think (name of OTHER person) may be able to help out with this but the level of delayed turnaround in (names the two counties) is about two minutes?
10	IT	Yes. Our hospital turnarounds have now returned to previous levels before the implementation of the Electronic Care Record System. It has taken a while to get to that point and we've had to put resources in such as halos to ensure we get to that point
11	COO	*Interrupts* But equally I think it stays the same as well. The system has developed since the initial implementation, so making it more user friendly in terms of the completion of the fields and the import of data which would have added to the delay to turnaround. You always expect it initially with the familiarisation of the system, but the system's equally improved since, where we shouldn't see greater impact with implementation in other areas.
12	IT	The training is built into this year's programme through (name's) timescales where we're deploying and as far as management and reporting of the project's concerned, name's now taken over as the lead on the project board for ECS and therefore there's a closer relationship to feed progress through to the board.
13	NX3	I was a bit concerned when it said 'awaiting release of date for the next software update'. I mean, why don't we know?
14	COO	That's actually driven externally.
15	NX3	I appreciate that.
16	COO	So we know when …
17	NX3	But whatever's external, we're holding the baby at the end of the day aren't we?
18	IT	The national programmes have seen a number of delays across all sectors, not just ambulance, and new dates are being released with the SHA very focused on those releases. And ECS is seen as a positive piece of news on the national programme, but it is recognised that the dates are unclear across a number of work streams.
19	COO	Release 4 was given the go-ahead yesterday here. It was implemented yesterday. They're in the testing phase and we have now 45 days' test to ensure the UNCLEAR.
20	NX1	I think it's fair to add that we don't get a great deal of notice in terms of when the release is likely to take place from the point we're told to the point of.
21	CH	Okay. Right. Thank you. Noted. Okay on to agenda item 6.7, page 7 (names DCS): this is the strategic objectives. Probably everybody very familiar with the change in day for example.

In response to the chair's invitation to speak, the IT representative firstly thanks the chair and proceeds to instruct his colleagues on how to treat the report; he locates it in a series of reports, describing it as an *'updated version'*, and sets expectations on forthcoming updates and progress. However, there is no description of the content of the report itself, indicating an assumption that the board is already familiar with its content.

The chair thanks him and then addresses the rest of the board, asking them: *'Are you happy with that?*'. His question is a leading one in that it invites certain types of responses and indicates what is an acceptable contribution to the subsequent discussion of the report. Here the chair plays an important role in inviting the reactions of those who may not be entirely *happy* with the update. This is further confirmed by the immediate response of the medical director: *'I think it's worth reporting some minor hiccups'.* He then elaborates on the nature of these IT-related 'hiccups' and concludes: *'It is an area we're going to have to keep a close eye on* ***from a clinical point of view'.*** Here we have an example of how the implications of an IT 'hiccup' in the electronic care record system reported during the discussion of 'Governance items' can be discussed *from a clinical point of view*. What is more, the clinical perspective is introduced in the discussion by someone with medical expertise and a leadership role in his field, the medical director. So, there is scope at this point for the clinical implications of the IT issue to be discussed further. After all, the medical director's utterance, '***from a clinical point of view'***, is vague enough for the rest of the board to ask for clarifications regarding implications on patient care and how they could be tackled or prevented. However, the interaction that follows progresses along a different path.

One of the non-executives requests permission to speak and starts by asking 'why?', prefacing this so that it appears a logical question to ask: *'I mean, I suppose the question is why?*'. He then proceeds to reconstruct the problem from an IT 'hiccup' to a more serious issue for which there are *'various references'* within the board papers, for example had *'a negative impact'* on two counties, *'enough negatives'* have come back, and *'everybody has certain cautions about* it'. At this point we see that the non-executive reads into the report of the medical director an attempt to trivialise a serious problem. He presents a series of facts (references in papers, negative feedback from others, training requirements, implementation problems) that serve as evidence that the IT problem is far more serious than the medical director describes it to be.

The non-executive is not satisfied by the medical director's promise that *'we're going to keep a close eye on'* it and requests further explanations regarding plans for its roll out and progress. The non-executive is also not satisfied with the medical director's promise to look at the problem *from a clinical point of view.* This shows in that after he reconstructs the size of the problem, he moves on to redefine the

nature of the problem, the essence of the matter: *'it's been hard to implement. It's an operational question'*. Thus what he says is not to be treated as a challenge to the medical director's expertise or to the importance of the clinical implications: *'the principles are all right and the benefits you get of it are brilliant'*. He challenges the operational faults of the new system and attributes the responsibility to the IT department, undermining their expertise to deliver.

The Higgs Report (2003) states that the responsibilities of the role of the non-executive director are:

- **Strategy**: NEDs should constructively challenge and contribute to the development of strategy.
- **Performance**: NEDs should scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance.
- **Risk:** NEDs should satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible.
- **People**: NEDs are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary removing, senior management and in succession planning.

The non-executive's utterances in this sequence are closely tied to his institutional identity. The aim of his discourse is to challenge and scrutinise the reports of the other board members, particularly as these relate to management performance and finances. This is further evidenced in a series of exchanges that follow between the chief operating officer, non-executive 3, non-executive 1 and the IT representative, who delivered the update on behalf of the director of information management and technology. During these exchanges, the chief operating officer and the IT representative attempt to defend the new IT system by constructing delays in turnaround as normal and expected at this phase of the implementation and by minimising the impact that these have. Even when non-executive 3 challenges them further about the release of the new software: *'why don't we know'?*, he and the chief operating officer engage in a debate as to whom should be held accountable for this. Arguably, this long debate on who is responsible for the IT problem takes place at the possible expense of discussion around the impact on patients. After a sequence of 13 turns since non-executive 3's initial challenge, the chair sharply intervenes to bring this interaction to a close: *'OK. Right. Thank you. Noted'* and moves on to introduce the next item on the agenda.

In terms of the research question on how boardroom processes affect conversations about clinical issues, there are two points worth highlighting at this point:

- A topic can be introduced as a clinical one depending on the institutional identity of the speaker (eg medical director talks about adopting a clinical perspective for an IT problem). However, whether or not an item on the agenda will be discussed *from a clinical perspective* depends on other members' institutional identities too; these identities dictate their actions.
- NEDs' turns in conversation aim to challenge and scrutinise. In doing so their contributions form the first part of an adjacency pair[6] which asks for a defensive answer in return, often from the person who raised the issue or the person whose authority was undermined. NEDs, therefore, play an important role in steering the discussion of the issues raised. In sequence A, the nurse executive does not intervene to elaborate on the medical director's account.

Although in this sequence non-executive 3 managed to steer the discussion about IT problems away *from a clinical perspective*, in the next sequence his attempt to scrutinise the nurse executive's report highlights some important clinical issues.

4.3 How board members discuss 'around' rather than 'about' clinical issues (Sequence B)

In the previous sequence, we saw how members in the board collaborated, albeit in an argumentative fashion, to co-construct an IT problem as an operational issue shifting attention away from patient and care-related implications. We also noted the important role of the non-executive in stimulating the debate after an issue has been raised.

In this second sequence, the nurse executive is scheduled to raise an item in the agenda listed under Strategic items. Her report and the ensuing debate occur almost two hours into the meeting.

[6] As people take turns in conversations, they attempt to achieve various social actions (eg greetings, requests *etc.*). An adjacency pair is a pair of such social actions that conventionally follow each other. In this case a question would conventionally be followed by an answer.

Table 4.2: Sequence B: Discussing 'around' clinical issues, Trust 2

No.	Participant	Comment
1	CH	Okay. Let's move on. Agenda item 7.1 foundation trust application update. (NE's name)?
2	NE	Thank you Chairman. I'm assuming that people have read the short briefing paper. Very quickly we've been through the 12-week Strategic Health Authority diagnostic process. We have, as a board, agreed our action plan and started work on that and key members of the FT Team at the SHA are coming along to help us as a critical friend over the next week starting this Thursday, to help us look at our IBP and long-term financial model. (side conversation) Some of the historic due diligence work that we need to do and highlight with us areas that perhaps were not making as much progress as we would like to or if we've, in effect, missed the point of what they would be looking for around assurance. It's almost like an early review so that's going to be really helpful. There's been an awful lot of work undertaken by the FT project team with (names a list of people) doing a number of events around the region to raise the awareness around FT but also around FT membership and we're getting quite a good response from those. So I'd like to record my thanks to those four people who in effect, sometimes get looked upon as backroom people but actually are doing an awful lot of work, face to face with the public and some of our staff at the moment. Other than that I'm happy to take any questions Chairman. (Chief exec sending text on mobile during nurse executive's speech)
3	CH	Okay. Thank you.
4	NX1	Five seconds, I know we are a bit up against it time wise. Quality accounts: I assume we always produce quality accounts anyway. So what do they mean by quality accounts? I understand the report on quality, yes.
5	CH	(NE'S name)?
6	NE	This is not about our report being of good quality. It's around us agreeing some key measures of quality in patient safety, patient experience and efficient working, which then become our quality account. And then we have a dashboard of information that is pulled together, which becomes our quality report, and it's a requirement this year on FTs to provide a quality report which is in addition to the annual report so that it is totally focused on aspects of quality around patient experience, patient safety and efficiency but again all linked back to clinical outcome and patient experience. But there will be, it's (hesitates), it's not complicated
7	NX1	(Interrupts) Rather than take time, send me an example, yeah? for speed?
8	NE	Well I'll be doing this, planned on
9	CH	(Interrupts) Examples could be on Monitor's website as well.
10	NE	(tried to speak) There are, yes.
11	CH	There's stuff on there about quality accounts. This change of emphasis from purely finance on to quality in the whole of (area). If you go on their web site there's a lot of stuff on there which describes what quality accounts are and how they are seen.
12	NE	(side conversation) Chairman, I'm happy to provide a one pager in the interim, but we were looking to have a proper briefing session where we can talk about it in full and actually look at some ideas around our four priority areas.
13	CH	That's the recommendation and that's why we've got this paper here. If everybody agrees it is now top of the priority list, that we should take that

No.	Participant	Comment
		subject as one of the prime subjects being discussed on (date of next meeting) and then that would address the issue when people say 'well what are they?', which is a good question, because they're a new term …
14	NX1	(Interrupts) The thing is that people use words like quality, you can see it all the time, and nobody ever says 'what does it actually mean?' if you are to change an operation. All this speak by politicians, it's the right word to say 'quality', but what do you mean? Blank.
15	NE	Yes. At the moment we've got a range of information and data and actions in various people's reports that could be pulled together in a quality report if that's what we, as an organisation, choose to do. However, as a FT, at the end of the year, we will have to do that anyway. Whether we leave it separate and where we prioritise our main objectives around that, but it is a term that's being used and attached to the new way of working to focus on the quality aspects.
16	CH	Okay, thank you. Right we move on then to item 7.2 (workforce diversity report?), which is the duty on the board to take this report forward as part of our single quality scheme. (HR name) please?

The chair's utterance, *'OK, let's move on'* serves a dual function. It responds to the previous turn and it also projects a forthcoming interaction (see Beach, 1993 for the use of 'OK')[7]. According to Clifton (2009), in management teams the chair has rights, unavailable to others, to mediate talk and to announce decisions. In this sequence, the chair dictates not only the allocation and sequence of turns (ie each contribution) but also the pace of the interaction. The phrase *'let's move* on' serves also as a request for the next speaker to speed up with their report. As a result, the nurse executive prefaces her report so as to be heard as a time-efficient and quick update: *'I'm assuming that people have read the short briefing paper'* and then *'Very quickly, we…'*. While complying with the chair's request for time efficiency, the nurse executive also attributes responsibility for the content of her report to other board members who are expected to be already familiar with it.

She then proceeds to report on the action plan agreed by her team, the steps that have been taken to look at their long-term financial model, and the people within her team that have been instrumental in delivering this plan. The Higgs 2003 report states that the *'board should set the company's strategic aims, ensure that the necessary financial and human resources are in place for the company to meet its objective, and review management performance'*. So, the nurse executive's report to the board is organised to attend to these institutional goals on financial and management performance.

7 Beach W (1993), 'Transitional regularities for "casual" okay usages', *Journal of Pragmatics, 19*(4), 325-352

Rather than waiting for the chair to set the direction of the discussion to follow, as seen in Sequence A, the board member who raises item 7.1 (ie the nurse executive), concludes her report by inviting questions. Unlike the chair, however, the nurse executive cannot open and close interactions or explicitly ask for other members' reactions to her report. She therefore uses a category-bounded activity, which is defining an expected attribute of her identity as an executive board member: *'I am happy to take any questions, chairman'.*

Her report is discussed within the institutionally appropriate framework. One of the non-executives interrogates further and the nurse executive responds. The chair occasionally intervenes to facilitate the interaction between the two and closes the discussion on this item signalling that the nurse executive has provided sufficient information to satisfy non-executive 1. What is of particular interest, however, is that the non-executive interrogates the nurse executive on what she has *not* reported.

More specifically, right after the nurse executive finishes with her initial report on the agenda item, the non-executive asks and receives the right to take the floor. On the one hand, there is a general institutional rule that non-executives are to challenge reports by executive members of the board (Higgs, 2003). On the other hand, however, in each interaction non-executives will orientate to this rule of challenge and interrogation differently. In this example, the non-executive's reaction to the nurse executive's report is to interrogate her while at the same time displaying their knowledge of the situation (on time constraints, '***I know*** *we are a bit up against it time wise';* on quality reports, '***I assume*** *we always produce quality accounts anyway';* and on the content of her paper circulated beforehand, '*I* ***understand*** *the report (is) on quality, yes'*. This turn further indicates that non-executives need to organise their turns so that they do not come across as too aggressive or too challenging.

The nurse executive responds to the non-executive only after the chair has requested her to do so. In this case, the chair becomes the moderator between two members of the board who run the risk of disagreeing with each other. This is further confirmed by the nurse executive's subsequent turn that refutes the non-executive's understanding of her report. She then proceeds to clarify what her report on good quality is about. It is during these clarifications that she makes references to clinical issues: '*It's around us agreeing some key measures of quality in patient safety, patient experience and efficient working which then become our quality account',* and *'it is totally focused on aspects of quality around patient experience, patient safety and efficiency but again all linked back to clinical outcome and patient experience'.* Although she starts to explain further, she stops and makes a repair saying that *'it's not complicated'*. This repair to what she was about to say signals the end of any further clarifications on the subject. In the same way that she builds her initial

account on item 7.1 on the assumption that people have read the written report, she also stops short, later on, from elaborating further on clinical issues. Her elaboration rests on the assumption that the way clinical issues are presented in her written report makes them easy for other board members to understand.

The non-executive's subsequent turn shows a commitment and builds on the institutional rule of time keeping, which was set from the start of this interaction, *'rather than take time, send me an example, yeah? for speed?'* He, therefore, agrees with the nurse executive that they are running short of time and that their priority is to move on with the rest of the agenda items. With this turn, the non-executive signals the end of his interrogation on the content of the report with a request to be sent an example. Six turns in conversation take place between the chair and the nurse executive, each of whom offers information on how to find further information on the subject. In the 13th turn, the chair announces, assuming that everyone agrees, that the discussion of the topic will be '*top of the priority list'* and *'one of the prime subjects'* in another scheduled meeting. That this decision serves to satisfy the non-executive is evident in the way the chair presents the non-executive's question as one shared by the majority, *'when people say, "well what are they?"'* and as '*a good question'*. The non-executive takes this as a hint to justify his question further and place it in a wider context of people using words without questioning their meaning. The nurse executive acknowledges his turn and then proceeds to explain how adequate information already exists – *'we've got a range of information and data'* – as well as different routes for disseminating this information.

Her final statement nicely summarises the topic of this current debate, which was **not** the content but the name of the 'quality reports': *'it's a term that's being used and attached to the new way of working to focus on quality aspects'.* As before, the chair closes this interaction in the same way that it was opened.

In terms of the research question on the impact of boardroom process on the conversations about clinical issues, points worth highlighting are:

- The chair dictates not only the allocation and sequence of turns but also the pace of the interaction. The effect of this determines whether or not discussion on clinical issues can take place at all and, if it can, the nature and time made available.
- The introduction of an item (eg by the nurse executive on quality accounts) on the assumption that people have read the written report circulated in advance may be reasonable. However, the assumption that the way clinical issues are presented in the written report makes them easy for other board members to understand is problematic. Lack of understanding hampers constructive and effective discussion about the issues.

4.4 How a discourse of 'moving on' discourages engagement with quality of care and patient safety issues (Sequence C)

In the previous sequence the nurse executive raises an item in the agenda under 'Strategic items'. Although interrogations from one of the non-executives brings up clinical and patient-related quality issues, the discussion evolves around how best to 'market' quality reports: how and when these are to be distributed among all interested parties and whether their name is a suitable one for these purposes.

There were two items in the agenda that were labelled so as to explicitly describe their patient-related content. The titles of these were 'Safeguarding children' and 'Safeguarding vulnerable adults'. By the time that these items were raised the meeting had lasted for two hours and 44 minutes. They were the last items on the agenda before breaking for lunch (see also Table 4.3 for the structure of the meeting).

Table 4.3: Sequence C: Raising patient-related issues, Trust 2

No.	Participant	Comments
1	CH	It's a very good answer, (names NE). I'm not going to get into the debate. (Laughter). Okay good. 4?
2	NE	8.4 the safeguarding report. It's around safeguarding children. It's just reporting back to the board that we've had a number of serious case reviews that we've been dealing with at the moment. But the two that we've got outcomes on are two child deaths in (names city) and there were a number of recommendations that were raised for partner organisations and there were none for (names organisation) from that review. However, as is our practice here, we have looked at other agencies' recommendations and made sure that any of those actions that would be relevant to us we've picked up. In addition there was a child death following an overdose of methadone and we had to undertake what's called an internal management review. So we had to look at all of our practices, right the way from how many calls that we'd had over the last five years to that family and that address, right the way through to the clinical action that was taken. We've sent that information off to the chair of the local safeguarding children board, who will be pulling all the reports together and sending them off to OFSTED and we await the OFSTED review on that. We're currently dealing with 7-9 of those requests a week at the moment. We're being absolutely inundated with them and OFSTED are all over them around the quality, but we're on the case. Just finally, a bit of information that the work is going on around the Laming Report, but most of the focus at the moment is around social care and basically all the bits that I've put into this report are things that are relating to the social services side of the recommendations.
3	CH	Thank you (names NE).
4	NX1	I just want to express my thanks. (names a person not present) and myself attended a master class the other day on safeguarding children and adults. We got lucky, we got a two for one job. And (names NE) and her team did an excellent job. They had a real passion for the subject and they knew what they were talking about. It was very informative. I just wanted to say

No.	Participant	Comments
		thank you. And the same, by the way, goes for the vulnerable adults as well. Two for one.
5	CH	Thank you (names NX1). We move on then to the vulnerable adults survey for 19, please (names NE). Then we'll be breaking for lunch.
6	NE	I'll be very brief. (Laughter). Chair, this report just gives the board a briefing paper around the three-year strategy for valuing people now, which is around people with learning disabilities. It's an area that as a trust, we've, because of other pressures, I think we've not placed as much emphasis around the particular needs that people with learning disabilities have. It's rising very quickly up the agenda with the Care Quality Commissionand indeed, Monitor, as a result of the recent Health Care Commission report about the care that people with learning disabilities were receiving, particularly in hospital. One of the key areas for us is recognising that those people with learning disabilities have a much higher incidence rate of illness and long-term conditions and so may have more frequent interaction with us. So it's something that we need to pull together, a proper … action plan and that's what I intend to do in the next couple of months once we've recruited to our vacancy. It was just to raise it on the board's agenda really.
7	CH	Okay. In that case we were promised a break for lunch, which has arrived. Thank you. Everyone join us for lunch and we will reconvene 1.30.

The nurse executive's presentation on both patient-related papers is organised in very similar ways and receives very similar reactions. She delivers these papers in turns two and six. She uses the word 'just' in the prefaces of both her accounts: *'it's just reporting back to the board'* and *'this report just gives the board a briefing paper*'. The word *just,* in both cases, indicates that nothing other than reporting the issue will take place. In a sense she sets the tone in which her report is to be discussed (or not, in this case). While minimising the need for further discussion on her reports, she emphasises the importance of the issues she is reporting on. In this way she signals that although her two reports do not need to be discussed, they, nonetheless, merit the attention of the board. She uses qualifiers such as *'a number of serious'* and *'a much higher incidence rate'* to highlight the size of the problem on safeguarding children and adults with learning difficulties. She then reports on the implications of these issues for her department and what action has or will be taken by her and her team to address these problems.

In her second and final report, she concludes by reminding other board members that she is not expecting the report to be discussed any further: *'just to raise it on the board's agenda really'*.

The only member of the board who takes the turn after the nurse executive's report was one of the non-executives. His own turn is a break from the usual sequential pattern of a non-executive member interrogating a speaker. Instead, he thanks and reports explicitly on his own training and implicitly on his own involvement, interest and knowledge in the area of safeguarding. He then thanks

the nurse executive, with whom he debated on her previous report on 'infection, prevention and control', and praises her work and that of her team. Expressing agreement and satisfaction with performance, here, proves to be an important interactional goal for these board meetings.

His joke, *'we got a two for one job'*, further works to alleviate the seriousness of the issues presented by the nurse executive – there is laughter around the board – and so they can all easily move on to the next and final item on the agenda. However, the terms 'safeguarding children' and 'safeguarding vulnerable adults' are social services terms, so the NED may well be just quoting the names of the courses he attended. Nevertheless, using those terms has the effect of dissipating the emotionally charged connotations with 'death' and 'illness' with which they were associated in the nurse executive's turns.

The chair corroborates with the overall mood in the boardroom and reminds them that they will be breaking for lunch right after he has introduced the final paper on 'vulnerable adults'. As soon as the nurse executive has presented her paper, the chair closes the meeting for the lunch break.

In this sequence the board did not engage in a discussion on safeguarding children and vulnerable adults. In terms of the research question about the impact of processes on conversations in the boardroom, we have noted:

- a crucial factor was the timing: these issues were allocated a time slot just before the lunch break and after almost three hours discussing other aspects of business
- the language used (by the nurse executive and the chair) had the effect of discouraging discussion.

4.5 Talking about 'spectacular successes' in patient outcomes (Sequence D)

In Trust 3, unlike in Trust 2, the quality of care and patient safety agenda in the board meeting observed prior to the development programme was not delivered by the nurse executive, but by the director of infection prevention and control. Even though the nurse executive did not have a pre-allocated turn in the quality of care and patient safety part of the board meeting agenda, she put herself forward to answer one of the chair's probing questions. The following sequence of interactions occurred under the quality and safety section of the agenda and in the context of discussing the infection report presented by the director of infection prevention and control.

Table 4.4: Sequence D: Talking about changes in clinical practice, Trust 3

No.	Participant	Comment
1	Chair	Talking about the prevention, I was er pleased to read about this PLG – I am not pronouncing it all in case I don't get it right. I don't know, do you want to say a bit more about that? Cause that sounds like an interesting idea.
2	Director of infection prevention and control	Yeah, that's eh it's not a new technology. It takes basically components of patients' own blood and this is then applied into wounds and it's been used for some time in cardiac surgery to promote the healing of wounds and err one of the cardiac anaesthetists has actually suggested that this be used in other chronic wounds and err the err showcase hospital initially funded some of it funded the initial parts of the project which saw absolutely spectacular successes, patients who'd had chronic wounds, leg ulcers that had been going on for years and years err virtually I won't say cured overnight, but certainly very much better within a matter of weeks and made a substantial and really significant impact on patients' lifestyles and their general quality of life. Obviously we're very keen to take that forward and I think at the moment we're looking to get some funding from the PCT.
3	Chair	Can I be clear? Was this one of our clinician's ideas or is it (director of infection prevention: *overlapping* Yes it is). I know it's been around but it's something that someone has taken an idea and used it.
4	NE	Apparently it's a technique that's used in our cardiac surgery routinely (chair: *overlapping* Right, right) and it was presented to our infection prevention committee err as this is something we'd want to consider to promote wounds healing and then therefore reducing the risks of infections. If you haven't got a wound you're (inaudible) to infection and I think it is worth saying that the PCT did fund the err PLG project (chair: *overlapping* mm-hmm) and err they have been very supportive in this and there are some real benefits, you know, here of spreading this out across the community (chair: *overlapping* Oh indeed, I know, yeah). Chronic wounds is actually a big thing (chair: *overlapping* Oh yeah, I know, yeah, yeah) for us in the health economy and a big risk for us in terms of infection So, it is a fabulous therapy (chair: *overlapping* It sounds great). It's quite onerous, though, it's not a simple therapy in terms of you treat a lot of patients very quickly and it takes a long time to treat one individual patient as in the duration of their treatment spell but err the results speak for themselves and have been, have been fantastic and in fact the quality of lifestyle, particularly for one gentleman (*chair coughs very loudly* – inaudible) that he is walking up to a mile a day again when he hadn't been walking 50 yards a day because of the pain of the chronic wounds on his legs (chair: *overlapping* fine).
5	Chair	*[names non-exec director*] you were an infection prevention committee member do you wanna say something?
6	NX4	Yes. I just wanted to ask (*names director of infection prevention*) a question. I've noticed there's a national conference in the autumn and one of the sessions in it says is it possible to have an MRSA-free region? and I'm not sure where that's coming from but what in your opinion, is stopping everybody from that final step to get rid of these ones and twos that crop up? Or is that just somebody's marketing very well? (*laugh in the boardroom)*

In turn 1, the chair highlights a section in the report on the prevention of infections that he '*was, err, pleased to read about*'. Reference to his emotional state at the time of reading the report serves to make the chair's engagement with the quality and safety agenda appear to be an honest and sincere one. Also notice how the chair confesses to not being able to pronounce the full name of this treatment. This confession of ignorance far from weakening his leadership in the boardroom, in this context it serves well as a preface to him asking the director of infection prevention and control to *'say a bit more'* about a treatment that has an unpronounceable name but it *'sounds like a an interesting idea'.* Even though the chair appears to request further information as if such a request could be turned down by the director, *'do you want to say a bit more about that?',* the institutional rules of doing board meetings require the executive members to respond to scrutiny.

In response to the chair's question, the director of infection prevention and control explains the history, process, funding sources, outcomes on patients and future plans regarding the treatment. The way that the director organises and delivers this explanatory account reveals what board members consider to be '*an interesting idea'* regarding clinical process. Right from the start, the director states that the technology is not new and then proceeds to construct a clinical process which is unremarkable (*'basically')*, simple and straightforward (ie takes components of patients' own blood and this is then applied into wounds) and '*it's been used for some time'*. Board members traditionally associate innovation with the discovery of a new technology, as the director's account suggests. He, however, having repaired this understanding goes on to define innovation as the transfer of a clinical process from one area of patient care (cardiac surgery) where it's been used for some time to another area (other chronic wounds). But it is in the description of the outcomes of this process on patients where the director attempts to persuade his audience regarding the merits of the clinical process. In this context, the director aims to draw his audience's attention not so much to the clinical process, or who came up with the idea, or even the funding that made it possible, but to the '*absolutely spectacular successes'* that the process had on patients. An emphasis on clinical process would equate innovation with new technology. Instead, the rhetorical construction of the size of the impact on the patients presents such an impact as extraordinary (*'spectacular successes'*, *'very much better'*, *'a substantial and really significant'*), so much so that the director and his team *'are very keen to take it forward'*, suggesting that this move will bring a change in clinical treatment.

The immediate response of the chair, in turn 3, is to further interrogate the ownership of this idea, *'was this one of our clinician's ideas?'* The director of infection prevention and control replies, almost monosyllabically, and at this stage, the nurse executive intervenes immediately to offer a more detailed explanation. She

orientates to the chair's concern about the ownership of the idea and she emphasises that it originated from within the trust: *'used in our cardiac surgery routinely'*, *'presented to our infection prevention committee'*, and *'the PCT did fund the PLG project and they have been very very supportive in this'*. The rest of her response is set to corroborate with and reinforce the explanation offered by the director of infection prevention. She builds up an impressive representation of the therapy and its impact: *'fabulous'*, *'quite onerous'*, *'results have been fantastic'*, and she manages to draw the chair into admitting: *'it sounds great'*.

The nurse executive further tries to bring the story of one patient into the boardroom in order to demonstrate the life-changing effects of the treatment (*'he was walking up to a mile a day again when he hadn't been walking 50 yards a day'*). However, her voice is quieter, making the personal story sound rather awkward in this order of the sequence, while the chair responds with a rather indifferent *'fine, fine'* as if he wants now to move on to another topic. Indeed, in turn 5, the chair asks one of the non-executives whether he wants to contribute to the discussion, justifying this turn allocation to the non-executive's previous role as a member of the Infection Prevention Committee. The non-executive then changes the subject.

In terms of the research question about how rich the dialogue is about clinical issues in boardroom conversation, two points are worth highlighting:

- It can be difficult for the clinical board members to bring patient stories into the boardroom, even in the context of reinforcing 'good news' (eg about a potential change in clinical treatment). It requires confidence by those introducing the story, time allowed by the chair and a willingness to engage by other board members.
- Reinforcement of an argument by the different clinical members of the board (eg the director of infection prevention and the nurse executive) can both prolong a discussion about clinical issues and increase the understanding about those issues.

In this chapter we have presented four sequences from the pre-programme board meeting transcripts. In the next chapter we present a further five sequences, selected to show how board members engage with some sensitive issues around quality of care and patient-related issues after the board had completed its training.

5 Boardroom conversations after the programme

In this chapter we present the remaining five out of nine sequences taken from the board meeting transcripts, together with our analysis of the conversations. While the four sequences presented in the last chapter were taken from transcripts before exposure to the Burdett Trust programme, the five sequences in this chapter have been selected from the post-programme transcripts. The sequences were chosen to illustrate how board members engage with some sensitive issues around patient-related issues.

The board at Trust 2 spent more time discussing papers around quality of care in the board meeting observed after the completion of the development programme. There were also more papers on quality of care presented by the nurse executive and these papers were presented in the first half of the meeting. The sections that follow, therefore, analyse sequences from discussion of papers on quality of care.

5.1 Requesting and offering assurances about the patient safety strategy (Sequence E)

Previously, we showed how in the meeting that took place prior to the development programme, the board failed to engage in a discussion on safeguarding children and vulnerable adults. A crucial factor was that these issues were allocated a time slot just before the lunch break and after almost three hours discussing other aspects of business. In the post-programme meeting that we observed, these issues were discussed at the start of the board meeting. The discussion which follows took place 35 minutes after the start of the board meeting, when the board appeared to be still fresh and well engaged with the agenda.

Table 5.1: Sequence E: Requesting and offering assurances on patient safety, Trust 2

No.	Speaker	Comment
1	Chair	We move on then to item 7.2 which is the patient safety strategy. This is a report that began as (INAUDIBLE) but is one that we reviewed in the board strategy group really and it's here hopefully in a revised form, but for quality purposes. Ok? We don't want to go through it all again.
2	NE	No, thank you chairman. You're absolutely right. It has that the comments from the strategy board have been incorporated into this. Although it says 'draft on it until it's approved', it's the final document.
3	Chair	Okay. Everybody happy with that?
4	NX1	I have a separate question. Not related to the detailed content but obviously the whole point of it is that it goes down the channel to staff. Are there plans to actually do that?
5	OEXE	I think probably the best way is to make sure that this is disseminated to the staff to make sure that general managers feed it down to their own station managers and that they raise it with their staff on a one to one basis, given their appraisals um, things like that. Through regular station routines. Clearly there's a possibility for articles on specific points, briefing and so on. I think you know, to a large extent, it's face to face to get it raised.
6	NX1	There's no point in having it unless everybody knows it.
7	Chair	Yes indeed. That's fine. Yes. *(ADDRESSES DF USING FIRST NAME)?*
8	DF	How do we make it a success? Is there a before and after?
9	NE	The, (INAUDIBLE) reporting health and safety incidents on a monthly basis, *(USES DF'S FIRST NAME)*. And those uh, patient safety incidents go to the commissioners quality review group and come to this board within my report every other month. And indeed it was part of uh, reviewing those and scrutinising them,that we came up with uh, patient safety priorities within the quality plan.
10	Chair	Yes.
11	NX2	A question. Is any of this going to be included in the mandatory training? So for example appendix 1 is a good one isn't it? Patient safety. So it just refreshes, it would be a good thing just to include because a lot of them won't have had the mandatory training. It's a good thing to include so it's all there.
12	NE	*(ADDRESSES NX2 WITH HIS FIRST NAME)*, within the new training programme that *(SAYS CHIEF EXECUTIVE'S FIRST NAME)* mentioned in his report, the clinical and risk team worked with, very closely with um, *(SAYS FIRST NAME)*'s head of um, training, to come up with that package, which includes uh, scenarios and patient uh, experience, case studies, which incorporate patient safety. Incorporate health and safety. Incorporate risk assessment, as well as how to canulate somebody, or how to resuscitate someone. And that's why I believe the, well we're world class now around our training package, because we've incorporated all of, all of our policies and our strategies within the training programme around patient scenarios to make it real for staff.
13	Chair	Good.
14	WOD	I want to say that we have included these in mandatory training in the past. But this year the emphasis is on making it a real experience and that's been the biggest change. Um, and some of the initial feedback from staff has um, has confirmed that that's a good thing.

No.	Speaker	Comment
15	Chair	Right. Thank you. I think the board's happy to approve the document now in its final form. Right. We move on then to uh, item 7.3 in the agenda.

As also observed in the meeting prior to the development programme, the chair once again indicates urgency for the discussion to 'move on'. Notice how the chair opens (turn 1) and closes (turn 15) the discussion on the Patient Safety Strategy Report. His introduction of the report further builds up the urgency by which the board is to deal with the report.

Right from the first three turns, the chair and the nurse executive co-construct the report on the Patient Safety Strategy in ways that curtail and discourage any further discussion about its content. In turn 1, the chair informs the board members on how they should treat the report on the patient safety strategy, which is to be presented by the nurse executive. The chair describes the report as an almost historical document (*'a report that began as'*), which contains information the board members are already familiar with (*'was reviewed by the board strategies'*). He further justifies its inclusion in the discussion agenda on the grounds of abiding by institutional rules for requesting and offering approval to strategy plans, *for quality purposes*. The chair does not explain or make any hints on why this particular report needed to be revised, why it failed to be approved in the first place, and what revisions were made to the original report. If the chair was to offer any information on the nature of the revisions, he would be introducing new information to the boardroom. New information, in turn, could initiate further discussion. Notice how the chair tries to repair his description of the report as one '*in a revised form'* with the phrases *'but for quality purposes'* and *'we don't want to go through it again'*. Providing any further information about these revisions could offer grounds for members to probe for further information, to ask further clarifications or even disagree. The nurse executive shows strong agreement with the chair: *'you're absolutely right'*. Instead of talking about a *'revised'* report, which could indicate something new and novel to the board, she says that comments have been incorporated into the original report as opposed to it being changed. She then directs attention to the title of the report, *'draft on it until it's approved'*, in order to repair members' potential impressions that the content of the report is still open for negotiations and to curtail any further discussion on its content: '*it's the final document'*. In this sequential order of turn taking, the chair's question *'everyone happy with that?'* is to be heard as a question that invites agreement to close the discussion.

The fact that the chair and the nurse executive have managed to curtail discussions on the content of the report is confirmed by non-executive 1, who in turn 4 prefaces his question on the report saying that his question is '*not related to the detailed content'*. Non-executives need to balance the demands of their role for

scrutiny with an obligation to abide by the level of inquiry allowed to them by the chair, who leads the discussion. In this instance, non-executive 1 inquires about plans on how to disseminate the report conclusions to the staff while manifesting his understanding of and agreement with the chair's request not to interrogate the content of the report. An executive member offers an answer to his question and the non-executive's response, *'there's no point in having it unless everybody knows it'*, works to defend his previous question as a commonsense and legitimate concern. The chair acknowledges the legitimacy of this line of interrogation: *'Yes, indeed'*, and it sets the boundaries of what is and what is not the acceptable line of inquiry about the patient safety agenda and effectively what are allowable contributions to the business at hand.

Two question-answer 'adjacency pairs' follow. The first pair (turns 8 and 9) deals with issues of quality assessment. The director of finance asks about the way success in patient safety is defined, particularly with regard to a pre-and post-situation: *'how do we make it a success? Is it a before and after?'* This is an information-seeking question. In response to his question, the nurse executive offers information about the frequency of monitoring and reporting on health and safety-related incidents and the analysis of this data to inform patient safety priorities within the care quality plan. Figures or narrative accounts of the size of the health and safety incidents recorded, as well as changes observed, are not mentioned and the nurse executive also offers no specific information on how data are evaluated to identify gaps or to measure success. Her descriptions of how data inform priorities remain vague: *'reviewing those and scrutinising them'*. Generally, her response works to offer assurances that the right process of monitoring success or failure is in place while, by avoiding disclosure of more specific information about these, discourages any further discussion on the matter. In the second question-answer pair (turns 11 and 12) non-executive 2 asks a question relating to quality improvement; he, however, does not request information but rather aims to make recommendations on actions to improve the quality of care. Again, the nurse executive's reply is to offer assurances that this is a course of action that they are already pursuing successfully. First, she uses the qualifier *'very closely'* to build up the rigour with which the training package is designed – *'the clinical and risk team worked with, very closely'* – with the head of training. Then she lists a series of activities and topics that the training includes to strengthen her argument for the quality of the training. She finishes with a statement which – although it is prefaced as a subjective evaluation, *' That's why I believe'* – is preceded by factual information that makes her ensuing argument an objective assessment of the situation: *'well, we are world class now around our training package'*.

In the subsequent three turns (13, 14 and 15), there are no more information-seeking questions, probes for clarification or recommendations. The chair states that this is an agreeable account to him, *'Good'*, and the director of workforce

development further backs up the nurse executive's assurances regarding the high quality of the training package by highlighting the sort of improvements in training that have taken place and the positive feedback they have received from training staff. Following this corroboration between the nurse executive and the director of workforce development and the immediate absence of any more questions or disagreements, the chair swiftly declares that *'the board's happy to approve the document now in its final form'* and moves on the next item for discussion.

In terms of the research question about the richness of the dialogue, we highlight that collaboration (between chair and nurse executive) discouraged discussions from revisiting the 'micro' content of a report. Instead, it allowed the space for more strategic 'macro' enquiries (eg about dissemination and quality assessment).

5.2 Investigating patient complaints (Sequence F)

As we have noted, discussions about complaints did not take place in the pre-programme meeting. In the post-programme meeting that we observed, the following discussion on complaints took place while discussing the 'Quality Dashboard and Directorate Performance Report' and that was an hour into the meeting.

Table 5.2: Sequence F: Discussing patient complaints in Trust 2

No.	Speaker	Comment
1	Chair	Okay. Thank you. We are finishing now
2	NX5	Nearly (laughs)
3	Chair	Oh sorry!(laughs) Are we going to talk about complaints?
4	NX5	Complaints, yeah.
5	Chair	Yeah. Just to bring to the board's attention that we're going the wrong way, yeah? Page 7. 6.2.1.
6	NX5	Formal complaints (paper shuffling)
7	NE	The complaints you're absolutely right, the complaints are going up. We have um, a um, disproportionate number of complaints around our patient transport service at the moment and uh, and, (name) and uh (name) and his team working with um, with the, the risk managers are doing an in-depth analysis around that. There's an awful lot of those complaints are around delay and um, and, our crews turning up uh, for PTS type, crews turning up, patient not being ready and then leaving and uh, and then that patient falling through the gap.
8	CE	(intervenes) Can, can I just add, what do you think, the, the, underlying issue is the fact that EDS have been standardising their computer-aided despatch system over the past uh, few weeks and have had teething problems with it.
9	NE	Mmmm (in agreement)
10	CE	I think from my understanding, I'm happy to be corrected by a colleague, it seems to me that um the teething problems have not been a technical nature, they've more been about staff um, not properly um, using the computer system

No.	Speaker	Comment
		correctly, which has led to mistakes and in some cases, delays.
11	DF	(intervenes) Which is about standardisation systems
12	CE	(overlapping) yeah, yeah
13	DF	if a system is working perfectly well, if it is already implemented, it's the transfers.
14	NX3	I understand the second review of complaints as I've done previously you're looking specifically at where there are a large number of PCS, the example I've randomly selected are obviously to do, around information to service user rather than actually the service in terms of why it was delayed, a different story been given, the wrong information being passed on. Um, but that does square with what you were saying.
15	NE	I see positive aspects around complaints is the drop. We've seen a reduction now around complaints regarding aspects of clinical care and again, I think that just links it, it just all ties up with the training, the communications and all of those sorts of things that we're doing.
16	NX5	Can I just say
17	Chair	(overlapping) Yes
18	NX5	I was a bit concerned that so many of the complaints were formal complaints. And you'd actually seen decreases of the informal ones and I wondered if there was any way we're handling the complaints that's actually turning them into formal ones from an informal one.
19	NE	There's been a change in, we've seen a change in the NHS passing around claim handling
20	CE	(overlapping) and I think if as (pause) that's right
21	NE	that's why
22	CE	(overlapping) as an organisation we are, we tend to over categorise stuff. We get a complaint and lot of, many org organisations um, tend to categorise lower than we do and so, unless it's of a very, very, serious nature, then they would, a lot of organisations will say that's an informal complaint. But we tend to, we tend to go the other way. So that's one probably one of the significant reasons why, one of the essential reasons why we've seen a greater increase…
23	NX5	(overlapping) Have we changed that? Because we're seeing an increase, have we changed our policy? Internally?
24	NE	We've changed the way that we're handling them as a result of the change in our policy.
25	Chair	Change, change them, which is also more informal.
26	NX3	Have we seen that, is that reflected across other trusts as well seeing similar increase (INAUDIBLE) the change, or formal complaints?
27	NE	Um, I can't answer, to be honest, I can't answer that question for other trusts really. Your point of view is…
28	MD	(intervenes) that we had before in Yorkshire where we were more similar to the national system now, it may have been less. *speech obliterated*
29	CE	I haven't looked at the up-to-date benchmarks. The reason why I make my (INAUDIBLE) 1.00.58 when we've looked through previous annual numbers of formal and informal complaints, compared to other ambulance services, they can't possibly be implying the same methodology that we use. Because some ambulance services of a similar size, the numbers of formal complaints they

No.	Speaker	Comment
		have, is like a handful. Now, you know, going back to the, my sort of theory, I don't know what the number is and I don't probably know what it should be, but I'm telling you that number isn't right. So it really demonstrates the fact that what we're doing is sort of more cautious end of how you can interpret it, rather than just saying there's only five that were really true out of 35 formal complaints and the rest were informal.
30	NE	There are, there are a number
31	NX5	(intervenes) there are different degrees of seriousness, right? It's whether they're a complainant seeking to make a really formal issue of it
32	CE	(overlapping) it's how you deal with it
33	NX5	and phoning up to say: 'look, this is the third time that I've had to wait'.
34	NE	It's how you deal with it, (addresses NX5 with first name)
35	CE	How you deal with it.
36	NE	How you deal with it
37	CE	How you deal with it
38	NE	How you deal with it. But, what I can do is, um, what's happening at a national level is that um, directors are taking a greater interest in some of the national working groups and um, and the methodology is um, that some of those areas are using to do some of this work that will be used uh, in a benchmarking exercise and you will recall that last year there was, there were questions around our clinical KPIs and one particular ambulance trust who was an outlier around being excellent uh in their KPIs and we then found was measuring it in a different way. So through the um, the director of clinical care group and the director of nursing group, we've agreed that directors will sit on each of these groups, so that we can make sure that the way that people are measuring is consistent. Because we could go back, uh, I'm happy, the next meeting I'll provide you with a fuller report around what's changed and where we sit in the benchmark with other organisations uh, in doing that, we need to for the future to be consistent, all of us need to be consistent with the way that we are measuring things and we have that agreement through clinicians.

The board meetings that we observed discussed a series of papers and reports circulated among them beforehand. The sequence by which each paper/report was to be discussed was fixed beforehand and in order for the board to proceed to the next report, they had first to make sure that they had covered all aspects relevant to the report at hand. This explains the repair made in turn 2 by one of the non-executives to the chair's attempt to close the discussion (turn 1) on a report delivered by the nurse executive. For conversation analysis, laughter has an interactional quality which extends beyond the realms of communicating a humorous event. As Vöge and Wagner (2010) point out, *'laughing is an activity that can be performed by more than one speaker at a time; it offers in fact the potential for interactants to act in unison'*. On this occasion, mutual laughter is a sign of agreement and consensus: the non-executive's utterance that aims to correct the chair closes with laughter and it is important to note that the other members of the board, including the chair, collaborate in laughing.

Although the role of the non-executive is to challenge and to scrutinise, this is not an easy interactional goal considering the power asymmetries within the board and, in particular, corrections directed towards the chair as the leading figure in these meetings. Notice how in turn 2, the non-executive attends to the delicate business of correcting the chair by using the word 'nearly' rather than 'no' followed by shared laughter and possibly the act of pointing to the chair the relevant section in the report. The role of laughter here serves three important functions: it helps the non-executive to correct another more senior member of the board; it enables the chair to accept and repair his mistake without losing face; and finally it allows the rest of the board to participate in the exchange, so diffusing the tension and moving on with the discussion. It is also worth pointing out that in this meeting non-executive 5 was serving as the vice chair, suggesting that this temporary role might have made her attempt to correct the chair a more acceptable act.

The topic of patient complaints was not listed as one of the agenda items. It was a small sub-section within a report on the 'Quality Dashboard and Directorate Performance Report', which the nurse executive was in the process of presenting to the board. This could explain why the item was introduced following a repair by one of the non-executives. After being corrected, the chair takes the lead in re-introducing the topic of patient complaints. Again, the chair introduces the topic of complaints in a way that aims to control how much time the board need to spend dealing with it: *'Just to bring to the board's attention that we're going the wrong way'*, followed by a request for confirmation, *yeah?* So, neither are the board members required to discuss complaints nor are they asked to take decisions on how to deal with these. According to the chair, the aim of this presentation is to raise awareness among the board members *'that we're going the wrong way, yeah?* The non-executive (also vice chair) further intervenes in turn 6 to specify the type of complaints to be discussed and in doing so to influence the direction of the discussion in a subtle way.

In the subsequent 32 turns in conversation, the board discusses information about an increase in formal complaints, which according to the charts they had in front of them, had tripled from one year to the next. In turn 7, the nurse executive presents the first account of an increase in formal complaints. Her account deals with the size, process of dealing with, and nature of the complaints. She uses a rather vague and technical word, *'disproportionate',* to describe the size of the formal complaints. She then points out that an in-depth analysis of these complaints is under way. This information has a two-fold purpose: it reassures the board that actions have already been taken to deal with these complaints while it also prepares them to hear her account of the events as a preliminary one since the outcomes of the in-depth analysis are still pending.

The nurse executive follows up with a description of a 'typical' incident in order to explain how and why patient complaints occur. For conversation analysis and discursive psychology, descriptions of events presented in a sequential order are powerful rhetorical devices. Not only do such descriptions work to draw board members into the scene of events as if they were there themselves, but they also function to explain events and attribute responsibility in ways that appear to be objective and unbiased. Notice the sequential ordering of events and the type of verbs used to describe these. The chain of events starts with *'the crew is turning up'*, whereby a direct action verb is used; in this case this is an action in line with the responsibilities of this NHS service. So, to start with, the crew are doing what they should be doing. Then, the scene that they encounter is described as the *'patient not being ready'*, where the vagueness of the word 'ready' in this context obscure the identity of the person(s) responsible for this. It also indicates a violation in the natural and expected order of events, ie the pre-condition that the patient is ready by the time that the crew arrives. As one event causes the next in this sequential order of narration, the crew leaving the scene is an acceptable and normal reaction to the patient not being ready, *'and then leaving'*. The fourth and final event that can also be heard as a consequence of the crew leaving is *'that patient falling through the gap'*. Notice the nurse executive's hesitation (um) before uttering this event and the vagueness in the description of what happens to the patient.

Descriptions of events such as these come across as impersonal and objective, which makes them very suitable when dealing with sensitive issues such as the report of complaints in this case (see Potter, 1996). Notice how the nurse executive uses more filler words (ums) here than elsewhere, further suggesting that complaints is a tricky issue to report in the board. It further indicates an uncertainty on the part of the nurse executive about the board's reactions at this preliminary stage of introducing the report on complaints.

However, in turns 8 and 10, the chief executive offers a strong cue regarding his engagement with the topic of patient complaints. He expresses his interest in getting to the root of the problem, *'the underlying* issue', and he presents the board with his view on the cause of the delays. His argument is bolder, though still carefully constructed, in that he blames NHS staff for the problems: *'they've more been about staff, um, not properly, um, using the computer system correctly, which has led to mistakes and in some cases, delays'*. He constructs a decision-making process whereby another department, the EDS, is held accountable for actions that take place before the crew arrives at the site where the patient is. The fact that he has shown an interest and has engaged in the report of the nurse executive along with explicit invitations for others' opinions (*'what do you think?'*, *'I'm happy to be corrected by a colleague'*) prompts the director of finance to engage in the discussion (see turns 11 and 13). He appears to agree with the chief executive's explanation

but at the same time he also shifts the focus of the blame from *'staff'* to *'systems'* and the chief executive agrees (turn 12).

In turn 15 and in response to the interest shown and direction given by the chief executive and others, the nurse executive presents a more reflective and explicitly subjective account of the situation (*'I see positive aspects around complaints'* and *'I think that just links it, it all ties up with the training, the communications and all of those things that we're doing')*. It is clear, in turn 15, how more comfortable and confident the nurse executive is when arguing for *positive aspects* and actions than when she is asked to delve into patients' negative experiences.

In turn 16, discussion about causality and accountability around complaints shifts, yet again, from a focus on the process of delivering a service to a focus on the process of recording and monitoring data on complaints. One of the non-executives, who was acting as the vice chair, acknowledges the nurse executive's account regarding decreases in complaints but also distinguishes between formal and informal complaints to re-engage the board in a discussion about the increase in formal complaints and the reasons behind this. Her interrogation of the data is designed to be heard as a disclosure of her inner states of mind, *'I was a bit concerned'* and *'I wondered if'*, which indicates to her audience that her engagement is sincere and that the issue affects her deeply, almost at a personal level. From that point onwards the board engages in a discussion about patient complaints which treats them as technical products of performance monitoring and benchmarking rather than as the outcomes of failure in patient care.

The most notable shift in the discussion about patient complaints can be observed in the arguments of the chief executive at the beginning and towards the end of the sequence. As a reminder, in turn 10 he dealt with patient complaints as outcomes of mistakes and delays attributed to staff who could not use the IT available: *'the teething problems have not been a technical nature, they've more been about staff um, not properly um, using the computer system correctly, which has led to mistakes and in some cases, delays'*. He was also very careful over how blame was to be attributed and made an explicit call for others to correct this interpretation.

Now compare turn 10 with turn 29 where the chief executive, in the context of what preceded his account, makes a very assertive claim that the number of complaints reported is misleading: '*Now, you know, going back to the, my sort of theory, I don't know what the number is and I don't probably know what it should be, but I'm telling you that number isn't right'*. The repetition of the phrase *'It's how you deal with it'* by the nurse executive and the chief executive functions as an undisputable conclusion to the inquiry about the increase in patient complaints. This repetition is mobilised, particularly to end the concerns of the non-executive–vice chair. The latter board member brings for the only time into the discussion about patient complaints, the voice of these patients into the boardroom: '*(they're) phoning up to*

say: ''look, this is the third time that I've had to wait'''. The exchange ends with the nurse executive promising to report on their organisation's performance compared with others and summing up the lessons learnt after discussing patient complaints in the boardroom: '*we need to for the future be consistent, all of us need to be consistent with the way that we are measuring things and we have that agreement through clinicians'*.

Another interesting aspect of the discussion is how each utterance is designed to appear as an agreement to the one that preceded it. Right from the start, when the chair says *'We are finishing',* the non-executive (turn 2) replies *'Nearly',* which is meant to be heard as 'yes, we are almost there but not yet' rather than 'No, we have something else to discuss' and so on. In turn 7 the nurse executive prefaces her account about complaints by expressing strong agreement with the chair: *'you're absolutely right'.* Also notice how in turn 8, the chief executive prefaces his utterance with the phrase *'just to add',* which is meant to be heard as an extension to the nurse executive's initial account, even though he offers a different view over who is to be blamed. Also in turn 11, the director of finance attributes blame to the *'standardisation systems'* rather than the *'staff'*, the latter view being uttered by the chief executive before him. However, the director of finance presents his utterance as an addition to the chief executive's one, using the word '*which is'.* The chief executive quickly accepts the director of finance's interpretation of the cause of the problem (see turn 12). Finally, in turn 14, the non-executive concludes his account with the phrase *'but that does square with'.*

In terms of the research question on how rich the dialogue is and whether any changes can be identified in discussions which took place after the development programme, we re-iterate that it was only after the development programme that we observed an attempt to tackle sensitive care-related issue like complaints at all. Three points worth highlighting which may have helped this happen are:

- How much more comfortable and confident the nurse executive is when arguing for *positive aspects* and actions as a result of lessons learnt rather than when she is asked to delve into patients' negative experiences.
- How much more engaged the board members are in a discussion about patient complaints which treats them as technical products of performance monitoring and benchmarking rather than as the outcomes of failure in patient care.
- Discussions rely on disagreement and contradictory positions to progress but the use of language and words in this sequence is designed to mask that conflict, encouraging more members to join in the discussion and allowing the discussion to be prolonged (eg each utterance appears as an agreement to the one that preceded it).

5.3 Pitching to develop new clinical services (Sequence G)

The following interaction took place at the post-programme meeting in Trust 3 after the nurse executive and the head of midwifery had together argued for the need to develop a midwifery-led unit. A discussion followed the presentation of these plans to which many board members contributed. As a reminder, Trust 3 did not spend, proportionally at least, more time discussing the care and patient safety agenda. However, the board's engagement with these issues was far more serious, tackling quality of care issues in more depth. The sequence that follows is an example of this more serious engagement Trust 3 showed in its post-programme meeting.

Table 5.3: Sequence G: Articulating the risk in developing clinical services, Trust 3

No.	Speaker	Comment
1	NX1	Can I ask you? How much additional capacity you've got though it's a big issue about capacity in, well, maternity units across the (names region) because we're anticipating a big bulge in the birth rate because that always happens when you get economic downturns apparently.
2	Head of midwifery (HM)	Yes it does.
3	NX1	But also there's going to be some reconfiguration on your borders soon that will have a big impact on it (HM: *overlapping* mm-hmm) so
4	HM	Well our capacity is good at the moment. If we get our own midwifery-led unit and 1,000 of our low-risk women go into there, that will increase our capacity on our hardest delivery suite err because on level 3 units we have a lot of in-uteri transfers. So err we've got good staffing levels now. We've got capacity.
5	NX1	But if that additional capacity in the low risk is midwifery-led staff, because that's probably where it's going to come (HM: *overlapping* mm-hmm) Do you have that capacity or not yet?
6	HM	Not at the moment without the midwifery of the midwifery-led unit, but the capacity for the midwifery-led unit will be 1,000 but I don't think we'll get 1,000 in the first year. That will take its time to increase because of people's confidence about the unit and the women wanting to book there and the knowledge of woman around the unit. So I'm confident that our capacity will change.
7	Chair	(Names NX4)?

In turn 1, one of the non-executives initiates a new sequence of interactions regarding the capacity of the existing maternity unit. He first alerts the head of midwifery that he has a question for her, attracting her attention to a potentially new line of questioning: *'Can I ask you?'* He then poses the question, *'How much additional capacity you've got though?',* followed by an explanatory account to justify the relevance of his question to the issue at hand. In his explanatory account, he

constructs a challenging situation whereby there is a large demand for maternity services because of increasing birth rates and changes in administrative boundaries. The use of quantifiers such as *'a big bulge in the birth rate'* and *'a big impact on it'* serve to maximise the risk. Halfway through this explanation, the head of midwifery acknowledges his assertion and it is worth noticing that the non-executive allows for this slot in turn taking. The head of midwifery's acknowledgment acts as a reassurance for the non-executive that he has attracted the attention and initial co-operation of the person from whom he seeks an answer.

In turn 3, then, he presents the second justification for his questioning. The head of midwifery's response, *'well our capacity is good at the moment*', works to reassure the non-executive that the unit does not face severe challenges in meeting demand currently, though the word *'good'* also suggests that there is room for improvement. Notice that in her next sentence she argues that the new midwifery-led unit could take the strain off, and help increase the capacity of their *'hardest delivery suite'*. She finishes her response by reiterating that the levels of staffing are *'good'* and that *'we've got capacity'*.

The hesitation in her voice along with a conservative evaluation of the situation as *'good'* do not satisfy the non-executive, who persists with his questioning. In turn 5, he specifies what he means when referring to *'additional capacity'*, which in this case is the midwifery-led staff, and then he proceeds to ask the head of midwifery a short question that requires a yes or no answer: *'do you have that capacity or <u>not</u> yet?'* Notice the emphasis on the negative response option, suggesting that such a response would be acceptable and may be expected. This is taken as a cue for the head of midwifery to reply *'not at the moment'* and then continue to explain why additional capacity among midwifery staff is not an issue *'at the moment'*. She argues that although the plan is for the unit to have the resources for 1,000 women, in reality it will serve fewer patients in the first year.

What is interesting in this exchange is how the non-executive, in order to ask a question, has to make it sound as worth taking the time of the board. In this case, he is achieving this by building up the risk that maternity services will not meet increasing birth rates. When the head of midwifery cannot reassure him that the resources are there to mitigate the risk, she minimises the risk of the demand and effectively renders the non-executive's concerns as not that important.

In terms of the research question about the nature of the dialogue in boardroom conversations about clinical issues, we note once again from this sequence that in the post-programme meetings we observed, board members favoured a positive and forward-looking discourse to tackling patient care issues (in this case how care will be affected by staff shortages).

5.4 What can and cannot be discussed by boards regarding quality of care (Sequence H)

So far, we have seen that questions by non-executives were always met with a response that aimed to satisfy them. In the next sequence of interactions in the Trust 3 post-programme meeting, this order is slightly violated when the chief executive steps in to remind the board of what questions they can and cannot address around clinical issues.

Table 5.4: Sequence H: Closing down a discussion, Trust 3

Turn	Speaker	Comment
1	CE	I don't think there's any doubts we are committed to delivering a midwifery-led unit err whatever happens here or elsewhere. We're committed to that. Err all that's at debate is the speed at which we do it. (HM: *overlapping* yeah) At present it's 18 weeks away. We would actually like to speed it up.
2	NX3	This is probably an ignorant question but should we be encouraging people to have births at home, I thought it was the other way around? Isn't it safer to have them in hospital?
3	HM	No, no, no! There's no if a woman's viewed as low risk it's as safe to deliver at home as it is in a hospital. It's a woman's choice. Some women don't want (NX3: *overlapping*, I told you it was an ignorant question *board laughs)* to deliver at home and then we should be able to provide the choice of a midwifery-led service.
	NX3	Right
4	NX1	I wouldn't go there (*some nervous laughing in the board*) because it's very difficult to work out those things.
5	CE	Okay? Okay let's remember that's not for us to work out. We've got a percentage that we've got to achieve and do not achieve it. We should be achieving it and it's not for this board to decide that policy.
6	CH	Okay let's move on. Thank you for that (names HM). I think we ought to just minute our thanks particularly to (names NX1) for his valiant effort to slip in a minute that we're anticipating a big bulge in pregnancies. *(Board laughs)* I thought that was wonderful. Thank you (names HM).

The sequence starts with the chief executive stating the trust's commitment to delivering a midwifery-led unit while implying that doubts may exist regarding other developments elsewhere, *'I don't think there's any doubts...whatever happens here or elsewhere'*. He then re-affirms their commitment and presents counter-arguments as not important: *'all that's at debate is the speed'*. This expression of commitment is interrupted in turn 2 by a non-executive's question. He prefaces his question as an *'ignorant'* one, which helps to set his question in a context of diminished responsibility. Notice how in turn 3 when corrected, he resorts to his self-characterisation as *'ignorant'* that helps him to save face and quickly backtrack from a potential argument. In turn 2, the non-executive expresses his puzzlement on whether they should be encouraging women to have home births when he

thought otherwise. He then very quickly mutters: *'Isn't it safer to have them in hospital?'*

The head of midwifery takes the turn to respond to his question, explaining why this is not the case. The word *'choice'* features twice in her short explanatory account. Interestingly, she defines the role of her unit as one with an obligation to provide choices to women. She therefore attributes a moral responsibility to their role as health practitioners for women. Unlike her, however, non-executive 1 and the chief executive do not accept his question as an appropriate one for the institutional requirements at hand. The non-executive uses humour to repair the question and the rest of the board uses laughter to diffuse the situation. The chief executive, however, as one of the two leading figures in the meeting does not laugh and instead reminds people with a serious voice that *'that's not for us to work out'*. He then goes on to list what the board should be concerned with, which is a figure that shows that the percentage of home births in their region is far lower than the national one.

In the context of the research questions it is worth noting that it is perhaps unsurprising for the board to find it easier to discuss clinical issues in the context of how they perform in relation to other trusts than to delve into the moral implications or underpinnings of care-related policies.

5.5 Drawing attention to the patient experience in the non-clinical topics of the agenda (Sequence K)

One of the main responsibilities of the nurse executive is to draw attention to issues of patient care when discussing other non-clinical matters in the boardroom. In the following sequence in the post-programme meeting in Trust 3, the nurse executive raises the issue of patient preferences with respect to extending operating days into three sessions.

Table 5.5: Sequence K: Highlighting the patient experience, Trust 3

Turn	Speaker	Comment
1	NE	I just wondered under NPAG on Option 2 about extending the operating day into three sessions, did NPAG have any feedback from patients about how they like that option or not?
2	COO	Not to my knowledge.
3	NE	Okay. I can imagine from my experience is most patients when they're having surgery, they want to know is it going to be first thing in the morning (COO: *overlapping* Yes)? Where am I on the list? (COO: *overlapping* Yes) And I wonder how people would feel about being on the third session err
4	COO	at 9 o'clock at night
5	NE	Yeah and I'm sure there would be some mixed feelings (COO: *overlapping* mm hmm).

6	NX1	(overlapping) Private sector's doing that all the time. They don't mind. (NE: *overlapping* What?) Coming in at 6 and having your operation at 9, they don't mind that.
7	NE	Nine at night?
8	CE	Yes.
9	NE	I don't think (*overlapping voices)* and that's a waste of bed space.
10	CE	And you're also dealing with a different clientele, yeah? (NE *overlapping* Yeah) We've got people who are very elderly, live on their own and they've got no one, you know, to even get them home and it would panic them with the thought of how you know, they're normally at home at 6 in the evening and to say, you know, that it is different. I agree with you it is possible.
11	NE	I don't know that. I just wouldn't.
12	CE	I mean no we know there's plenty of evidence to show, particularly around waiting lists. We have done seven day a week working. Let's be quite honest about it. We've done plenty of seven day a week working and I need to remind this board when we used to do a lot of seven-day working you were very concerned about the high financial cost of paying people to do those hours. There is another alternative to building this theatre, let's go back to when we were paying out, it ran into millions didn't it?

In turn 1, the nurse executive asks the chief of operations, who delivered the report which she refers to, whether the National Performance Advisory Group for Operating Theatres received patients' feedback on how they liked the option to extend the operating day into three sessions. Following the chief of operations' negative reply, the nurse executive questions the appeal of this option among patients. To make her argument more robust, she points to her experience (which translates as expertise in this case) and brings the voice of the patient in the boardroom using active voicing, *'Where am I on the list?',* to make her claim appear as factual as possible.

One of the non-executives and particularly the chief executive do not agree with her supporting this option. Of particular interest is the reaction of the chief executive, who in turn 10 also attempts to construct the experiences of patients in order to argue against the nurse executive's claim. Mobilising the patient experience, therefore, can also work as a discursive tool which is not exclusive to the nurse executive. The more detailed descriptions of patients are regarding individual circumstances (*'live on their own'),* feelings (*'it would panic them'*), and actual thoughts (*'where am I on the list?'),* and the more expertise the speaker has about these patients (*'from my experience'),* the more real these stories become and as factual accounts become stronger evidence.

In this sequence, however, the last utterance belongs to the chief executive, who when the construction of patient stories does not work to win the argument, resorts to a financial argument. He presents his audience with the threat of overspending: *'there's another alternative to building this theatre, let's go back to when we were paying out, it ran into millions, didn't it?'*

In terms of the research question about the richness of conversations, we noted a greater use of patient stories in this sequence. In particular we saw the following:

- Patient stories are powerful tools, especially useful for clinical members of the board where they can point to their experience (which translates as expertise in this case) and bring the voice of the patient in the boardroom.
- Stories are not exclusive to clinical members and can be worked up in different ways to argue for conflicting points of views.
- In the end, we saw that financial discourse has more power to persuade in the board than patient stories.

5.6 Summary of board talk findings

This chapter and the previous chapter have presented the findings of the board meeting conversations. It has also shed light on two of the research questions:

- How **rich is the dialogue about clinical issues** in boardroom conversations and is there any evidence that dialogue changes following the programme's interventions?
- How does the way a board operates influence the nature of the **conversations about clinical issues**?

We have found through listening to all the board transcripts that engaging board members with the quality and safety agenda is not an easy task. We did, however, find some differences in dialogue between the pre- and post- programme board meetings and selected extracts which reflect both the difficulties of talking about clinical issues and attempts to overcome these difficulties.

For instance, before the programme's interventions we saw that narratives of success are sought by board members (see Sequence E) and generate less critique for the speakers to defend these (see Sequence D). However, success in clinical care does not appear to generate as much argument as more controversial subjects such as patient complaints. The largest engagement with the patient care agenda, in terms of numbers of board members involved, that we recorded is in Sequence F, where six board members are engaged in a discussion regarding an increase in patients' formal complaints. In the pre-programme meetings, we did not record a similar attempt to tackle sensitive care-related issues. Controversial issues on the quality of care and patient safety agenda can thus increase engagement. We noticed in the post-programme meetings that the board would try and tackle such issues. However, argument relies on disagreement to progress and board members tend to declare agreement even when they present a contradictory position (see Sequence F).

Institutional rules of what is and is not an acceptable line of interrogation about clinical issues are created in the course of meetings (see Sequence H). It is also easier for the board to discuss clinical issues in the context of how they perform in relation to other trusts than to delve into the moral implications or underpinnings of care-related policies (see Sequence H).

Patient stories are powerful tools but these stories can be worked up in different ways to argue for conflicting points of views regarding their care. At the end, financial discourse has more power to persuade in the board (see Sequence K).

Finally, the board meetings we observed favoured a forward-looking discourse in tackling patient care issues, such as what lessons can be learnt, how training can be informed (see Sequence E) or how care will be affected by staff shortages (see Sequence G).

6 Individual Contributions to Board Meetings

This chapter is the last of the five that present the findings of our various analyses of the board meeting transcripts. This particular chapter moves away from looking at the content of what was said and presents an analysis of roles played in four trust meetings by the board members. Two meetings each in Trusts 1 and 3 have been examined for this purpose. Two methods of analysis have been used. Firstly, we looked at how long each board member spoke in each meeting in order to assess how much influence they potentially had. Secondly, we looked at how they interacted with one another by tracking the turns taken in the interactions. This provided an indication of the effectiveness with which each board member could fulfil their role and share concerns within the trusts. It also reflects the interest of the meeting in the topics raised by the individual concerned.

When looking at the contributions of the roles to board meetings in 2009 and 2010 it is tempting to make a direct comparison, but it must be remembered that the meetings can be very different. The number of members present may vary and the individuals concerned may change. The agenda, although following a broadly similar pattern, is likely to be composed of different items. However, if these caveats are borne in mind, it is still possible to draw some general conclusions about the impact of the board development programme on the trusts' boards. These will be outlined in the sections that follow.

6.1 Contributions by job role

The analysis of contribution by role is based on the number of words uttered by each individual and is used as a proxy for the length of time they spoke in the meeting. Speaking at length is not always the most effective influencing strategy in meetings. However, since speaking too little may not provide people with the opportunity to both present their point of view and promote their interests, we

consider using speaking time be an acceptable approach for our purposes in identifying influence.

The findings are given by role rather than individual as we are interested in clinical engagement by the board. It is reasonable to assume that the more time the clinically trained members of the board have to present their viewpoint and raise questions, the more likely the board are to be concerned with these topics. The nurse executive and the medical director and chair of the Professional Executive Committee (Trust 1) are the board members most directly concerned with patient issues and particular attention is paid to their contributions. It should be borne in mind that the contributions can be based on more than one person. This is always the case for non-executives and other executives and their numbers are given in brackets in the charts.

Two figures are shown for each trust as it became apparent when considering the transcripts that there were two types of contribution: reporting and general discussion. The reporting often consisted of a prepared speech given without interruption which outlined an agenda paper. This was followed by discussion and questions which gave all the other committee members a chance to contribute and give their point of view.

Interestingly, the lengths of the board meetings as measured by words spoken increased in the two trusts where there are complete recordings. The increases by individual trust were: Trust 1, 12 per cent and Trust 3, 106 per cent. This suggests that an outcome from the board development programme has been a more thorough discussion of issues.

Owing to the varying lengths of the meetings, the spoken contributions of members will be analysed using percentages rather than the actual numbers of words spoken. Figure 6.1 and Figure 6.3 show the percentages for the total number of words spoken by each of the main roles at the meetings in Trust 1 and Trust 3 respectively, while Figure 6.2 and Figure 6.4 similarly give the percentages of unprompted words from each of the main roles (ie when prepared presentations/reporting is taken out). The findings are shown in all figures for 2010 and 2009.

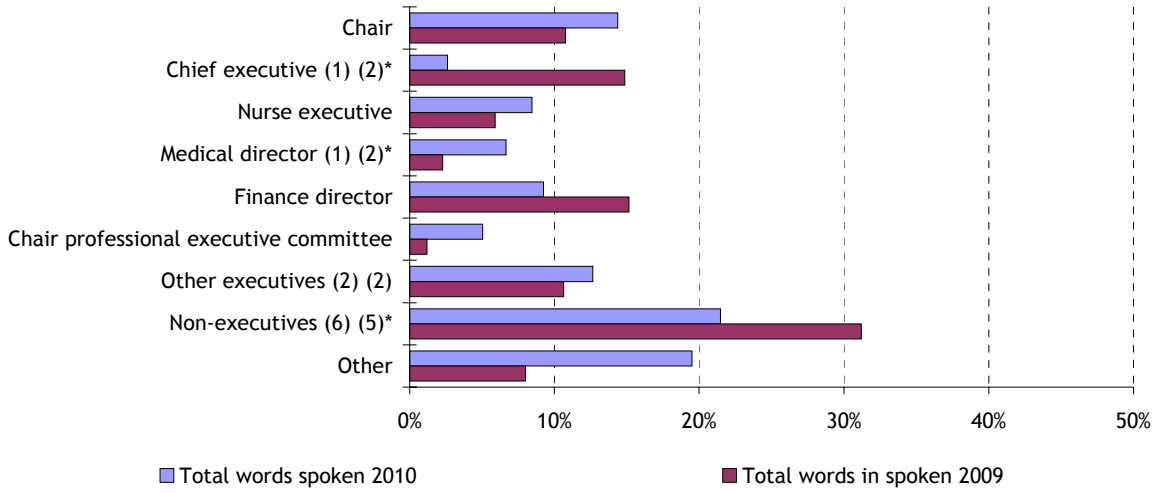
Trust 1: Contribution by job role

In Figure 6.1 for the board meeting at Trust 1 it can be seen that both meetings were dominated by the non-executive members, although to a lesser extent in 2010. The chair was the individual who had the most to say in facilitating the meeting and his contributions increased by a third in 2010. The more clinical members of the board, ie the nurse executive, medical director and chair of the Professional Executive Committee all made greater contributions in 2010, with

their combined total rising from 9 to 20 per cent. This is in contrast to 2009 when the board members with clinical responsibilities took the least part in the proceedings.

In Trust 1 the free exchanges in which items are discussed increased by 24 per cent over 2009, reflecting greater debate and discussion.

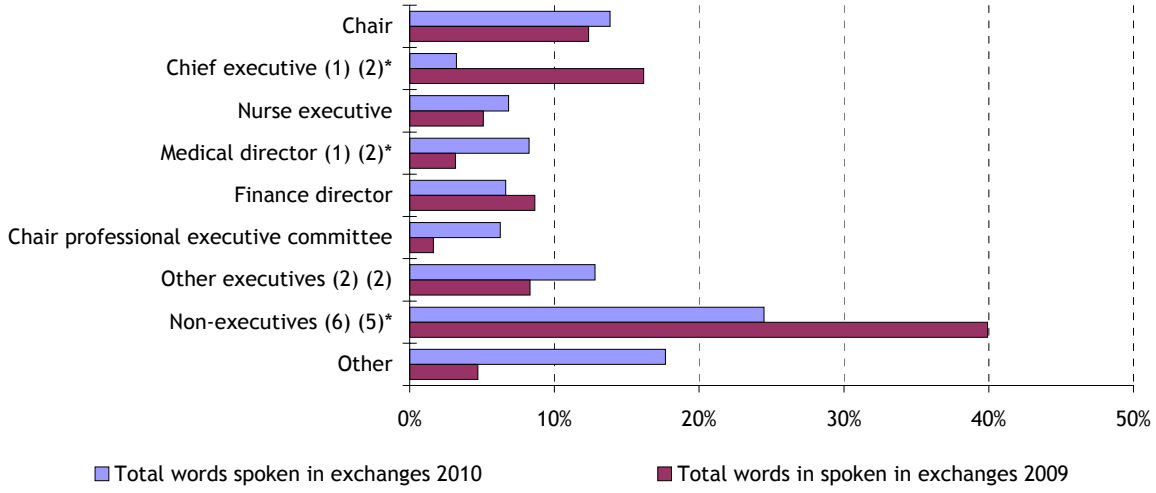
Figure 6.1: Trust 1: Comparison of total words spoken, 2010 and 2009



Note: *Number of meeting attendees with same role 2010 and 2009

Source: IES, 2009 and 2010

Figure 6.2: Trust 1: Comparison of words spoken in discussion only (ie excluding reporting), 2010 and 2009



Note: *The number of meeting attendees with same role in 2010 and 2009

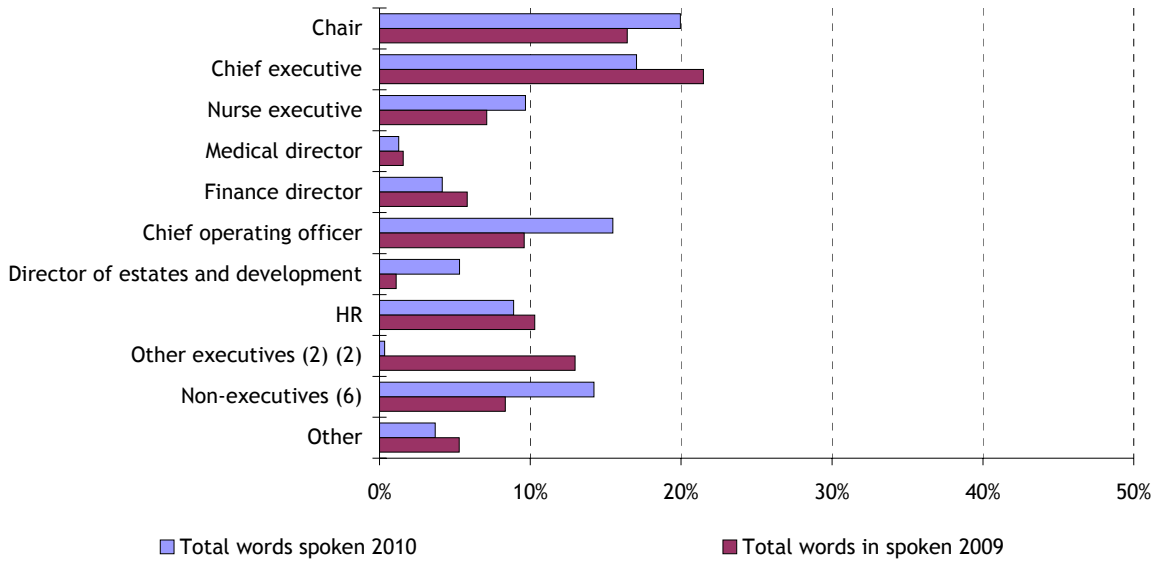
Source: IES, 2009 and 2010

Figure 6.2 shows the contributions made to the meetings by the various roles within these overall figures. The members with clinical responsibilities continue to show a significant rise in their contributions from 10 to 21 per cent, suggesting that their increased influence was not due to more reporting but related to more active engagement in the meeting.

Trust 3: Contribution by job role

A different pattern of contributions is seen in Trust 3 compared with Trust 1. Here the chair and the chief executive spoke for longest in the meeting in both years with the chief operating officer having a significant role. The nurse executive and the medical director represented those with greatest clinical interest in this trust and their combined contribution rose from 9 to 11 per cent from 2009 to 2010. The non-executives played a much lesser part here.

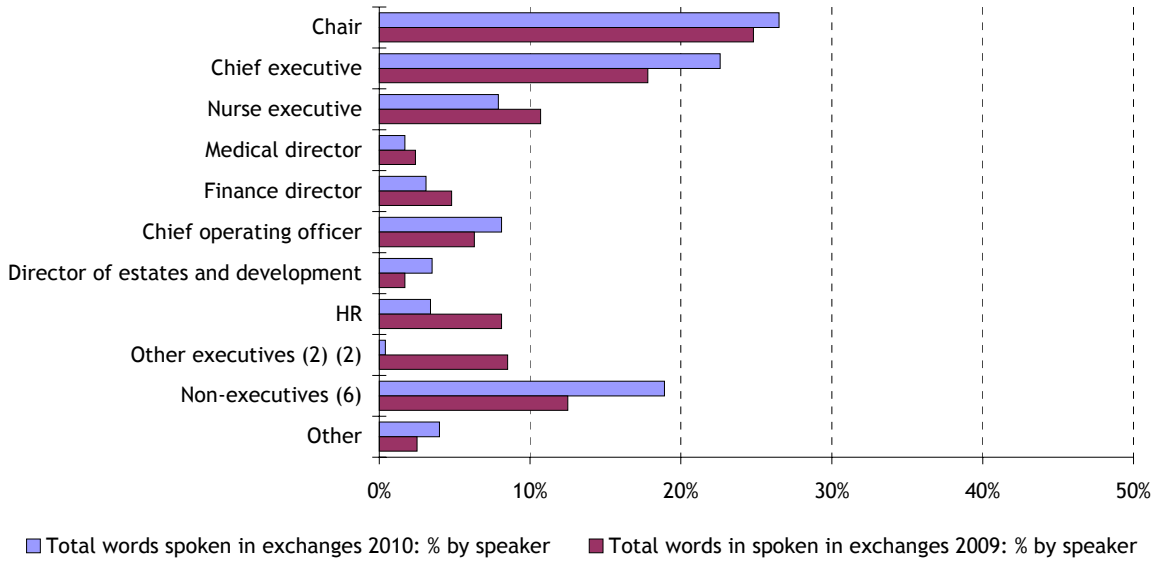
Figure 6.3: Trust 3: Comparison of total words spoken by role, 2010 and 2009



Source: IES, 2009 and 2010

However, when reporting is removed from the figures as shown in Figure 6.4, the contribution of the nurse executive and the medical director falls from 13 per cent in 2009 to 10 per cent in 2010, indicating that their enhanced profile was due to increased reporting rather than active discussion.

Figure 6.4: Trust 3: Comparison of words spoken in discussion only (excluding reporting) by role, 2010 and 2009



Source: IES, 2009 and 2010

6.2 Sequence of contributions by job role

The sequence of contributions to the board meetings was analysed by using a grid with the speakers as row and column headings. The first speaker's role was identified in the row headings and the role that replied in the column headings, and the interaction was recorded at the intersection of the two. This gave the opportunity to study the interactions by looking at which roles spoke next after each speaker. In this analysis we particularly focused in the key roles for our study ie the chair, nurse executive, medical director and chair of the Professional Executive Committee. For Trust 1 results we found that the following:

- The number of interactions increases for all of the key board members considered between 2009 and 2010. This is most marked for the chair, whose contributions have almost trebled, possibly reflecting a change in his style of facilitating meetings. His remarks are most frequently followed by the non-executives as a group and by the nurse executive when individuals are considered.
- The nurse executive's contributions have more than doubled and she is most often followed by the chair, indicating that there is considerable dialogue between them. The percentage of her interactions with the medical director has reduced while that for the non-executives has increased.

- The medical director and chair of the Professional Executive Committee in 2010 have increased their contributions to the meeting and are both engaged with a much wider number of roles on the board.

For Trust 3 we found a different pattern:

- The chair has also increased his contributions by 50 per cent but this is against a background of the meeting length doubling, suggesting no great change in his approach to chairing.
- The nurse executive was making far more comments here and was also addressing a slightly wider number of roles; however, the chair and the chief executive remained the roles most likely to follow up on her remarks.
- The medical director in this trust said very little in either meeting but was similarly predominantly followed by the chair and the chief executive.

6.3 Chapter summary

This section has outlined two techniques for analysing the roles of the board members in trust meetings. In the analysis it has been possible to describe the total amount of time the person in each job role on the board spent contributing to the meeting to indicate which roles potentially have the most influence. It has also been possible to consider active discussion separately from the more formal presentations of report contents supporting agenda items. In addition, the interaction of board members has been illustrated by considering the pattern of responses to speakers.

The findings worthy of note concerning the changes in the board discussions before and after the development programme are as follows:

- Board meetings have become longer.

In all three trusts it was observed that the meeting length increased, possibly indicating greater involvement in, and discussion of, agenda items.

- Board members with clinical responsibilities increased their contributions.

It was noted in 2009 that those occupying job roles with the greatest responsibilities for clinical issues outside the boardroom spoke the least. This had improved after the programme with the contributions of the nurse executive, the medical director and chair of the Professional Executive Committee all showing increases. In one trust this was due to a more active participation in discussions while in the other it was the result of more reporting.

- Board members with clinical responsibilities interact with a wider number of roles.

In both trusts where it was possible to track the sequence of interactions, the nurse executives, medical directors and chair of the Professional Executive Committee were all interacting with a wider numbers of roles to present their point of view.

- Change of chair's facilitating style.

In both of the trust board meetings we analysed how the chair interacted with all the other members, although in one trust there was a marked change in the number of interactions, with it almost trebling. Since there was no change of chair during the intervening period, this indicates a change of chairing style. We cannot say for sure that this is due to the development programme, but it may be.

In the next chapter we move away from examining the board meeting conversations in just three of the trust boards to present our findings from the on-line surveys conducted with both executive and non-executive directors from the boards across all the trusts participating in the Burdett Trust programme.

7 Survey Respondents and their Expectations of the Programme

7.1 Surveys in context

This is the first of two chapters presenting the findings from the two surveys of over 70 executive and non-executive board members (NEDs) across all the NHS organisations who have participated in the Burdett Trust/King's Fund programme. In this chapter we introduce the surveys, outline the respondent profile and present board members' expectations of the Burdett Trust programme. You will note that throughout these two chapters we refer to the nurse executives as nurse directors. This is because feedback from NEDs was that 'nurse director' was a term they could more easily relate to and therefore this is the term we used in our surveys.

The first survey (pre-programme) asked respondents to report their level of agreement or disagreement with 53 statements addressing their thoughts on patient care, patient safety, the role of the nurse director, and the working and communication of the board. The respondents were also asked for their views on the development programme and some personal background information.

The second pair of surveys (post-programme) asked respondents to report their level of agreement or disagreement with up to 64 statements addressing their thoughts on patient care, patient safety, the role of the nurse director, and the working and communication of the board. The respondents were also asked for their views on the development programme and some personal background information.

The results of the pre-programme survey offer a baseline position against which the post-programme survey can be compared.

A total of 71 responses to the pre-programme survey were received. This represented a response rate of over 50 per cent, which is good for this type of

survey. A total of 33 responses were received across the post-programme surveys. This represented a response rate of 30 per cent.

Please note we decided to include foundation trusts in the 'trusts' category as we anticipated that some trusts might achieve foundation trust status during the course of the evaluation.

7.2 Respondent profile

7.2.1 Gender

A breakdown of responses by gender shows an equal number of males and females in the pre-programme survey (see Table 7.1). Two people did not specify gender. In the post-programme survey, slightly more females than males responded and two people did not specify their gender.

Table 7.1: Distribution of responses by gender, percentage

	Pre-programme numbers	Pre-programme percentage	Post-programme numbers	Post-programme percentage
Male	34	47.9 %	15	42 %
Female	35	49.3 %	21	58 %

Source: IES pre-programme survey, 2009 and 2010

7.2.2 Organisation and role

A breakdown of the distribution of responses by organisation is shown below in Table 7.2.

Table 7.2: Distribution of responses by organisation, by number and percentage

	Pre-programme numbers	Pre-programme percentage	Pre-programme percentage (excl trust 7)	Post-programme numbers	Post-programme percentage
Trust 1	7	9.9%	11.3%	6	15.8%
Trust 2	9	12.7%	14.5%	7	18.4%
Trust 3	9	12.7%	14.5%	7	18.4%
Trust 4	7	9.95	11.3%	3	7.9%
Trust 5	9	12.7%	14.5%	2	5.3%
Trust 6	9	12.7%	14.5%	3	7.9%
Trust 7*	9	12.7%	-	-	-
Trust 8	7	9.9%	11.3%	4	10.5%
Trust 9	5	7.0%	8.1%	6	15.8%
Total	**71**	**100%**	**100%**	**38**	**100%**

Notes: *Did not participate in the post-programme survey

Source: IES pre-programme survey, 2009 and 2010

All the nurse directors completed the pre-programme survey, while seven out of a possible nine complete the post-programme survey. Only a small number of medical directors responded to the pre- and post-programme surveys. The largest response to both surveys comes from other executive and other non-executive members (see Table 7.3 below).

Table 7.3: Distribution of responses by role on the board, percentage

	Pre-programme frequency	Pre-programme percentage of all responses*	Post-programme frequency	Post-programme percentage of all responses*
Nurse director	9	12.7%	7	18.4%
Medical director	3	4.2%	1	2.6%
Chief executive	7	9.9%	2	5.3%
Chair	7	9.9%	2	5.3%
Other executive member	22	31.0%	8	21.1%
Other non-executive member	23	32.4%	18	47.4%
Total	71	100%	38	100%

Notes: *Percentage taken out of all respondents to the survey

Source: IES pre-programme survey, 2009 and 2010

The roles of those who ticked 'other' on the pre-programme survey included:

- board director – non voting
- director foundation trust development
- director of corporate services
- director of primary and community care
- director of public health
- HR
- NED
- Professional Education Committee (PEC) chair
- leading on strategy and planning as a commissioner
- trust board secretary (non-voting)
- TU – not non-executive member.

The role of the one individual who ticked 'other' on the post-programme survey was described as 'executive director'.

7.2.3 Association with the trust/PCT

The mean number of years respondents were associated with the trust/PCT was 5.5 years in the pre-programme survey and 6.7 years post-programme. The majority of pre- and post-programme survey respondents (pre: 67.6 per cent, post: 60.5 per cent) had been associated with the trust/PCT for less than five years (see Table 7.4). The spread was from less than one month to 39 years.

Table 7.4: Distribution of responses by number of years associated with the trust/PCT, percentage

	Pre-programme frequency	Pre-programme percentage	Post-programme frequency	Post-programme percentage
Less than 1 year	14	19.7%	3	7.9%
More than 1 year, less than 3 years	18	25.4%	6	15.8%
More than 3 years, less than 5 years	16	22.5%	14	36.8%
More than 5 years, less than 10 years	14	19.7%	9	23.7%
More than 10 years	9	12.7%	6	15.8%

Source: IES pre-programme survey, 2009 and 2010

The mean number of years respondents had been serving on NHS boards was 6.5 years in the pre-programme survey. This rose to 6.7 years in the post-programme survey. Over half of respondents to the pre- and post-programme surveys had served for more than five years, including two respondents to the pre-programme and three respondents to the post-programme survey who had served for over 20 years (see Table 7.5).

Table 7.5: Distribution of responses by number of years serving on NHS boards, percentage

	Pre-programme frequency	Pre-programme percentage	Post-programme frequency	Post-programme percentage
Less than 1 year	8	11.3%	4	10.5%
More than 1 year, less than 3 years	8	11.3%	6	15.8%
More than 3 years, less than 5 years	14	19.7%	5	13.2%
More than 5 years, less than 10 years	24	33.8%	15	39.5%
More than 10 years	17	23.9%	8	21.1%

Source: IES pre-programme survey, 2009 and 2010

7.2.4 Front-line experience

Respondents were asked if they had any personal front-line job experience as a provider of patient care. Table 7.6 shows that over half of pre-programme survey respondents did not have any such experience. The balance shifts in the post-programme survey, with just over half of respondents having had front-line experience as providers of patient care.

Table 7.6: Personal front-line job experience as a provider of patient care, percentage

	Pre-programme frequency	Pre-programme percentage	Post-programme frequency	Post-programme percentage
Yes	29	41.4%	17	53.1%
No	41	58.6%	15	46.9%

Source: IES pre-programme survey, 2009 and 2010

Among the 29 pre-programme respondents (41 per cent) who did have experience in front-line patient care, there was a wide variety of backgrounds and experience and these are summarised below. This question was not asked in the post-programme survey.

Nearly half (n=13) were described as having a nursing background while a quarter (n=7) had experience in varying clinical specialties/roles such as cardiology, paediatrics, ambulance clinician, physiotherapist, consultant obstetrician and clinical scientist. Three respondents were general practitioners and a further five respondents had educational or administrative experience, eg medical research, contract management and operational management.

7.3 Views on the development programme

Pre-programme survey respondents were asked about their understanding and expectations of the development programme on which their board was embarking. As shown in Table 7.7, while over half felt informed, over 40 per cent felt inadequately informed or not informed at all.

Table 7.7: Extent to which you feel informed about the development programme, percentage

	Pre-programme frequency	Pre-programme percentage
Well-informed	6	8.6%
Informed	35	50.0%
Inadequately informed	22	31.4%
Not informed	7	10.0%
Total	70	100%

Source: IES pre-programme survey, 2009

We asked respondents to comment on expected outcomes for nurse directors, the trust and PCT, and the next two sections report on the findings about these expected outcomes.

7.3.1 Outcomes for the nurse director

Pre-programme expectations

The majority of pre-programme survey respondents anticipated that participating in the programme would have a positive impact upon the nurse director at their trust/PCT, particularly through:

- building the confidence and profile of the nurse director as a board member (12 mentions), eg:

  'Will empower the nurse director to raise the effectiveness of the 'nurse voice'… most specifically re: patient care.'

'Empower [the nurse director] to highlight clinical issues.'

'Build up [the nurse director's] confidence to bring clinical matters to the board.'

- enhancing the effectiveness of the nurse director in encouraging and supporting the board to focus on patient care issues (13 mentions), eg:

  'Help [the nurse director] progress clinical quality improvement with colleagues on the board.'

  'Support for bringing patient care issues to the board.'

  'More effective in leadership and influence.'

- bringing clarity and development to the nurse director role, thereby reinforcing their contribution (eight mentions), eg:

  'Clarity in role and responsibility.'

  'Further strengthening the role of the nurse director.'

  'Support development as a critical board member who needs to ensure quality is as important as finance at the board.'

- improving skills and knowledge (six mentions), eg:

  'Build wider skills in mobilising the board and aligning it.'

  'Tips for how to get difficult issues on agendas and stimulate discussions appropriately - [the nurse director] does this already, but further development always useful for this agenda.'

- providing the nurse director with support (three mentions), eg:

  'A supporting network which will add to existing focus.'

  'It will give [the nurse director] support in their role, as well as information to improve the trust's activities.'

  'Nurse director could see more support from the board and be more challenged by the board on quality of care and patient safety matters. The nurse director could have greater options for securing clinical engagement to enhance quality and safety.'

Seven respondents were unclear about the impact that the programme would have, which probably reflects some of the comments regarding the lack of information, eg:

'Uncertain as I am not clear about the scope of the initiative or what outcome measures are.'

'Don't know enough about the programme to offer an opinion.'

Additional comments were:

'May engender a change to [the nurse director's] annual objectives or an extension to their portfolio.'

'There is a real challenge in getting both the nurse director and commissioner's responsibility for patient safety, care and satisfaction across the health economy established in practice and at board level.'

Post-programme effects

The most commonly reported effect of the programme by post-programme respondents was an increase in the confidence and empowerment of the nurse director, as well as a raising the profile of the nurse director and patient quality and safety issues. Comments highlighted a number of areas of achievement:

- increased confidence/empowerment (12 mentions), eg:

  'Given her more confidence to initiate discussion on issue.'

  'It has given her greater confidence regarding the presentation of patient care and safety (including safeguarding) and she is a highly valued board member.'

- profile raising of clinical issues (11 mentions), eg:

  'Brought patient quality to the fore in a co-ordinated way.'

  'Reality check of where NEDs are in their understanding of patient experience.'

  'Positive experience, and enabled board to have greater understanding of patient safety and nurse executive .'

- role development (three mentions), eg:

  'Focused her work with the board to produce high-quality board information.'

Four respondents were unsure what impact the programme has had, eg:

'I am not clear what the specific effect of participating in the programme has been. I am aware that our nurse executive makes a critical contribution to our board.'

There were two additional comments:

'Coaching has been particularly beneficial. Opportunities to explore relationships and influencing skills.'

'Enabled the introduction of an electronic Quality Assurance Framework for the board.'

7.3.2 Outcomes for the trust/PCT

Pre-programme expectations

Respondents were also invited to comment on what effect they anticipate that participating in the programme will have on their trust/PCT. Pre-programme respondents most commonly felt that key outcomes of the development programme for the trust/PCT would be:

- an increased profile for patient care and safety issues by the board (15 mentions), eg:

  'Increase board discussions appropriately around clinical care and patient safety… incorporate appropriate clinical SWOTS to board agendas.'

  'It will ensure we address our patient responsibilities in all areas of our business direction.'

  'Greater board involvement in clinical issues.'

- an increased confidence and understanding of patient care and safety issues by board members (nine mentions), eg:

  'Greater understanding by the board, of those quality and safety issues which are key to the organisation, clarity around what they should expect, ask for and challenge.'

  'Develop competence and awareness of quality of care and patient safety matters, also be clearer or even have a idea of where we need to address gaps to improve clinical engagement.'

- building knowledge and best practice learning (six mentions), eg:

  'Strengthen shared clinical knowledge base amongst board members.'

  'Increased understanding about clinical governance for the NEDS.'

- building and reinforcing the role and contribution of the nurse director (six mentions), eg:

  'Director of nursing will assume a position of influence and patient care and patient voices will be heard more.'

  'Increased value of contribution from and through senior nurse representatives.'

- improved communication (four mentions), eg:

  'Clarity of procedures for raising patient quality and patient safety issues through the nurse director and getting them discussed by the board. Hopefully, it will

provide a much rounded approach to looking at the issues and designing potential solutions.'

'A more vigorous and robust basis for discussion at board level including an improvement in the quality of information the board receives.'

- greater strategic emphasis on patient care and safety (four mentions), eg:

  'Enable the trust to develop its strategies/processes and procedures with regard to quality of care and patient safety.'

  'Greater strategic emphasis on clinical/patient safety issues.'

- support in leadership to achieve organisational goals (two mentions), eg:

  'Assistance with overall business leadership needed for foundation trust status.'

- a change in the relative importance of, and links between, quality, finance and efficiency (four mentions), eg:

  'Quality will be seen as important as finance.'

  'Greater clarity at board level about what constitutes a discussion that relates to patients. Some board members don't always see links between patient care, outcomes, quality, service improvement and therefore don't think we speak about many patient-related issues.'

Five additional comments included:

'I am hoping that the programme will focus specifically on clinical quality improvement via the contracting mechanisms we now work.'

'Improved clinical governance.'

'Consistent approach to quality and safety and increased understanding of the issues, prioritising and clinical care standards.'

Four respondents were unclear at this stage, or did not know what the impact of the programme might be.

Post-programme effects

As anticipated by pre-programme respondents, the most commonly cited effect of the programme on the trust/PCT by post-programme respondents was a rise in the profile of patient safety and quality issues in the board. Comments spanned a number of areas of achievement following the programme:

- profile raising (16 mentions), eg:

'Made us more aware of the patient experience.'

'It has enabled the board to reflect on priorities and the functioning of the board.'

'We have changed our board agenda and approach: patient care and safety is now discussed as the first main item and is now priority number 1 for the trust.'

'Raised the issue of the role of nursing executive to higher profile.'

- provided useful feedback for the board (five mentions), eg:

  'We have all received very positive feedback on board process and some useful feedback.'

  'We have had some useful feedback about the operation of our board, and we have discussed this as a board... Over the last year we have changed our committee structure to focus more on quality and safety issues. This committee - supported by our nurse executive - has really raised the profile of quality and safety issues with the board - and meant we have much more systematic processes for considering and addressing quality and safety issues, with a regular quality report coming to the full board.'

- improved clinical engagement (two mentions), eg:

  'Improved clinical engagement with board, especially NEDs. Revised clinical structure, improved professional and personal development of clinical leads. More effective communication between exec and non-exec, more efficient board meetings with a clear focus on patient safety and care.'

  'Much more challenging and focused on patient quality issues and NEDs very supportive.'

Although the vast majority of respondents reported positive outcomes from the development programme, a small minority were underwhelmed by the programme (five mentions):

'Re execs - positive. NEDs less so.'

'Irritated some, thought it was all about the nurse director, others have considered patient feedback in more detail.'

'Always good to have another pair of observing eyes and feedback. Have to honestly say that the assessor's comments were not memorable, but I'm not on the safety or patient experience sub committees where I expect more was discussed about this scheme and its impact.'

'Minimal apart from the development of the nurse executive.'

'None.'

In the next chapter we present the results of the survey items relating to self-perceptions of the clinical engagement of board members, in which we will see an increased rating on the majority of items when we compare the mean (average) scores from pre- and post-programme surveys.

8 Survey Results: Perceptions About Clinical Engagement

This is the second of two chapters in which we present the findings from our surveys. In this chapter we present the views of board members on a range of clinical engagement items, comparing perceptions before and after exposure to the development programme. The clinical engagement issues include care quality, patient safety, the role of their nurse executive, the workings of their board and communications on their board.

Respondents were asked to state their level of agreement/disagreement with a series of statements using a 5-point scale (1=strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree: this scale relates to the x-axis in Figures 8.1 to 8.4). The section contains a mix of positively and negatively worded statements. For the purposes of analysis and presentation, the scores for negatively worded statements have been reversed. This enables high scores to indicate satisfaction, and low scores dissatisfaction, consistently throughout the report. The affected statements are identified by a single asterisk.

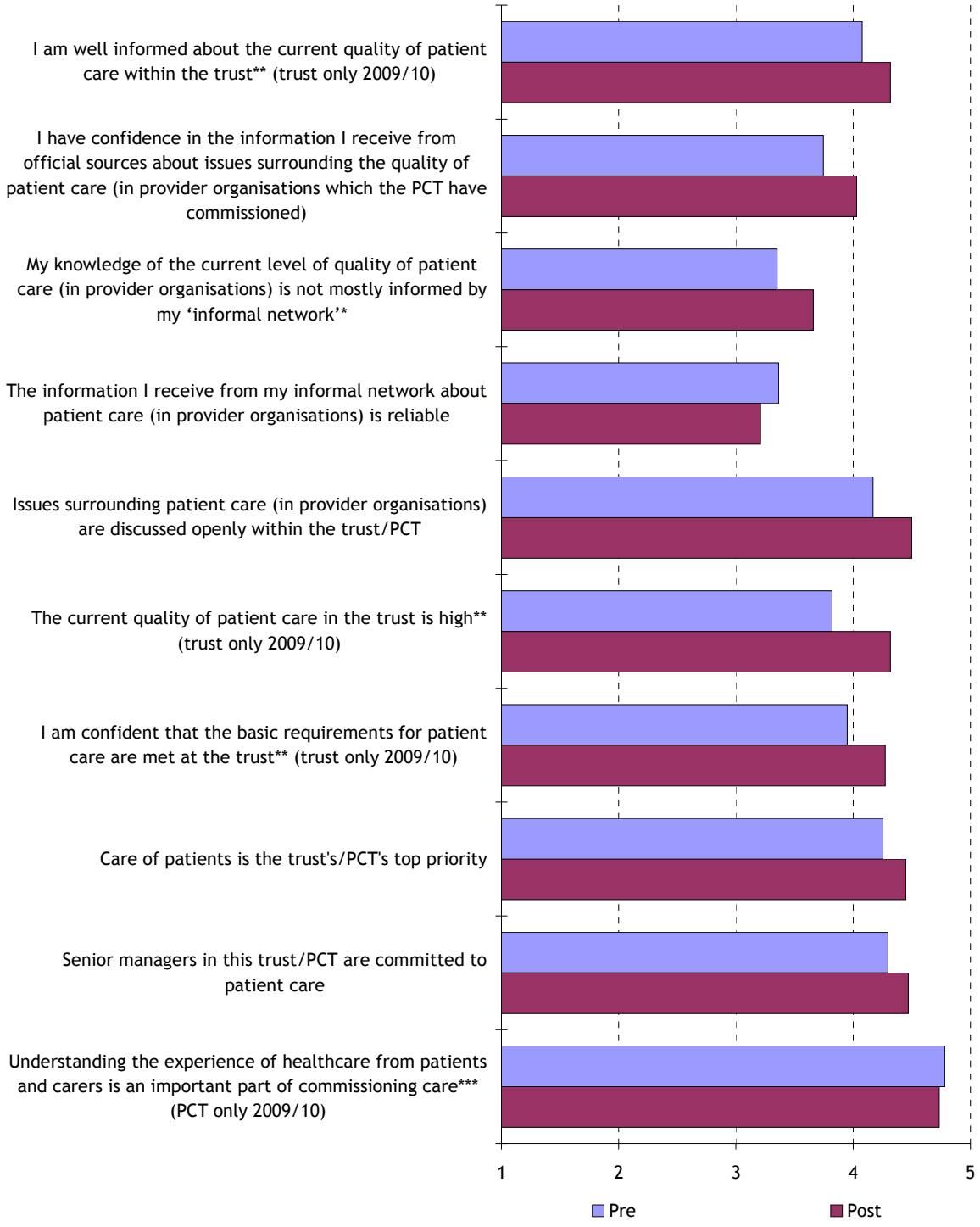
Several statements were only appropriate for respondents from provider organisations and not primary care trusts (PCTs) or vice versa. Such statements are shown clearly as being 'trusts only' (data from the four PCTs is excluded) or PCTs only (data from provider organisations is excluded). The affected statements are identified by a double or triple asterisk respectively.

The key findings are described below.

8.1 Patient care

Respondents were asked their views on patient care within the trust/PCT. Score averages (means) have been calculated for each statement relating to their thoughts on patient care; these are shown in Figure 8.1.

Figure 8.1: Your thoughts on patient care, mean values



Notes: * Negatively worded statement score has been reversed for comparison purposes; ** Trust only statement; *** PCT only statement

Source: IES pre- and post-programme survey, 2009 and 2010

There were improvements in 8 out of 10 items relating to members' personal perceptions of patient care. Figure 8.1 shows that the largest rise in mean score

relates to the current quality of patient care in the trust rising from an average of 3.82 to 4.32 – indicating a higher prevalence of agreement post-programme on this item.

One item which went down was reliability of information received from informal networks about issues surrounding the quality of patient care. It could be that this is because confidence in the reliability of information received from official sources went up. The other item that went down was a PCT-only item which was understanding the experience of healthcare from a patient's and carer's perspective is an important part of commissioning care.

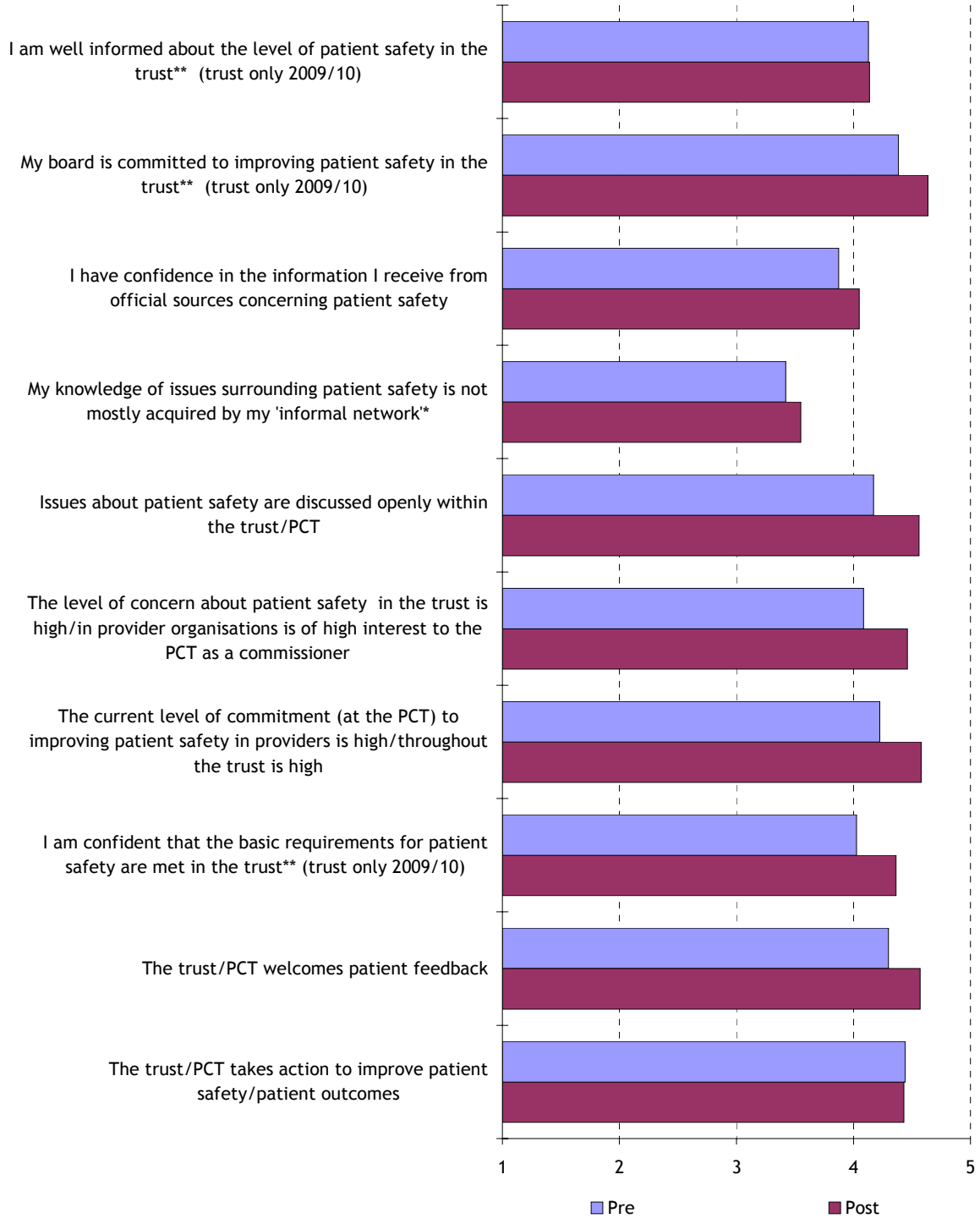
Appendix Table A2.1 provides more detail about all ten of the items within the patient care category. Notable improvements in perceptions are as follows:

- Eighty-nine per cent of pre-programme survey respondents agreed that issues surrounding patient care (in provider organisations) are discussed openly within the trust/PCT. This rose to 95 per cent post-programme. Eighty-nine per cent of pre-programme survey respondents believed that senior managers in the trust are committed to patient care. This rose to 92 per cent post-programme.
- Less than three quarters of respondents from provider organisations neither agreed nor disagreed that the current quality of patient care in the trust (before the programme) is high. In the post-programme survey 100 per cent agreed that the current quality of patient care is high.
- Three-quarters of pre-programme survey respondents from provider organisations were confident that the basic requirements for patient care are met at the trust. In the post-programme survey, 100 per cent of respondents agreed that the basic requirements are met – a rise of over 25 per cent.

8.2 Patient safety

Respondents were asked their views on patient safety within the trust. Score means were calculated for each statement relating to their thoughts on patient safety; these are shown in Figure 8.2.

Figure 8.2: Your thoughts on patient safety, mean values



Notes: * Negatively worded statement score has been reversed for comparison purposes; ** Trust only statement

Source: IES pre- and post-programme survey, 2009 and 2010

Figure 8.2 shows that the largest change in mean value relates to the statement: 'Issues about patient safety are discussed openly within the trust/PCT', rising from

4.17 to 4.56 on average. Eight out of ten items showed improvements in perceptual ratings after the programme, while two stayed the same. The big changes (improvements) are around concern, commitment and boardroom discussions.

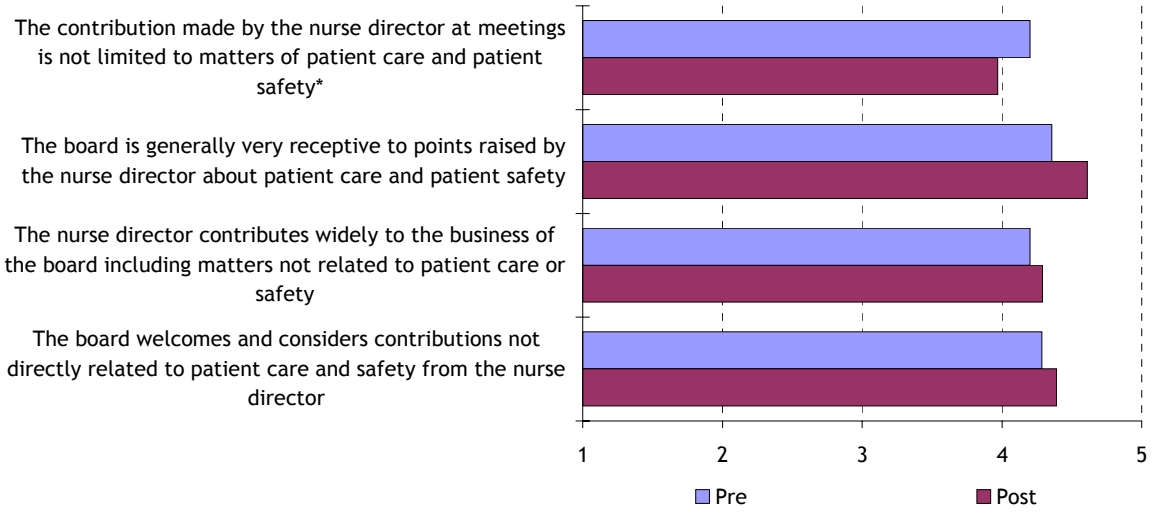
Appendix Table A2.2 provides more detail about all ten of the items in the patient safety category. Notable details from the appendix to highlight are as follows:

- The majority of both pre- and post-programme respondents believed that the trust/PCT welcomes patient feedback.
- Eighty-nine per cent of pre-programme respondents agreed that issues about patient safety are discussed openly within the trust/PCT. This rose to 100 per cent post-programme. The proportion who strongly agreed rose by 30.9 per cent from 28.6 per cent pre-programme to 59.5 per cent post-programme.
- Nearly all (97.4 per cent) post-programme respondents agreed that the current level of commitment to improving patient safety throughout provider organisations is high compared with 85.9 per cent pre-programme.
- All pre-programme respondents agreed that the trust/PCT takes action to improve patient safety/patient outcomes. This was the only item about patient safety where the ratings went down (very slightly) after the programme. This is in part because one post-programme respondent disagreed that the trust/PCT takes action to improve patient safety/patient outcomes. This serves as a reminder that the perceptions of improvements are not universal.
- One hundred per cent of post-programme respondents from provider organisations agreed that the board is committed to improving patient safety, compared with 92.3 per cent pre-programme.
- Just under one fifth of pre-programme respondents from provider organisations neither agreed nor disagreed that they were confident that the basic requirements of patient safety are met in the trust, including 2.6 per cent who said they were not confident. In the post-programme survey there was universal agreement that the basic requirements are met.

8.3 The role of the nurse director

Respondents were asked their views on the role of the nurse director. There are improvements in three out of four items relating to the role of the nurse executive. Means have been calculated for each statement relating to the role of the nurse director; these are displayed in Figure 8.3.

Figure 8.3: The role of the nurse director, mean values



Notes: * Negatively worded statement score has been reversed for comparison purposes

Source: IES pre- and post-programme survey, 2009 and 2010

The most notable difference in mean scores pre- and post-programme relates to the item 'The contribution made by the nurse director at meetings is not limited to matters of patient care and patient safety', which shows a fall in mean score from 4.2 to 3.97 – indicating a decline in agreement with this item post-programme. It may be that the programme focused attention on the role of the nurse director in bringing safety issues to the fore, thereby either reducing other contributions or making them less visible to the other members of the board.

Appendix Table A2.3 provides more detail on the four items within the role of the nurse director category. These include the following:

- Nearly all pre-programme respondents agreed that the board is generally very receptive to points raised by the nurse director about patient care and patient safety. This rose to 100 per cent agreement post-programme. Nearly all pre- and post-programme respondents agreed that the board welcomes and considers contributions not directly related to patient care and safety from the nurse director.

- Just over ten per cent of post-programme respondents disagreed that the contribution made by the nurse director at meetings is not limited to matters of patient care and patient safety, nearly double that of pre-programme respondents (5.7 per cent). A higher proportion of pre-programme respondents agreed with this statement than post-programme (88.5 per cent compared with 78.9 per cent respectively).
- While the majority of pre-programme respondents agreed that the nurse director contributes widely to the business of the board including matters not related to patient care or safety, 15.7 per cent neither agreed nor disagreed and 2.9 per cent disagreed with this. Just 2.6 per cent of post-programme respondents showed uncertainty and no respondent disagreed.

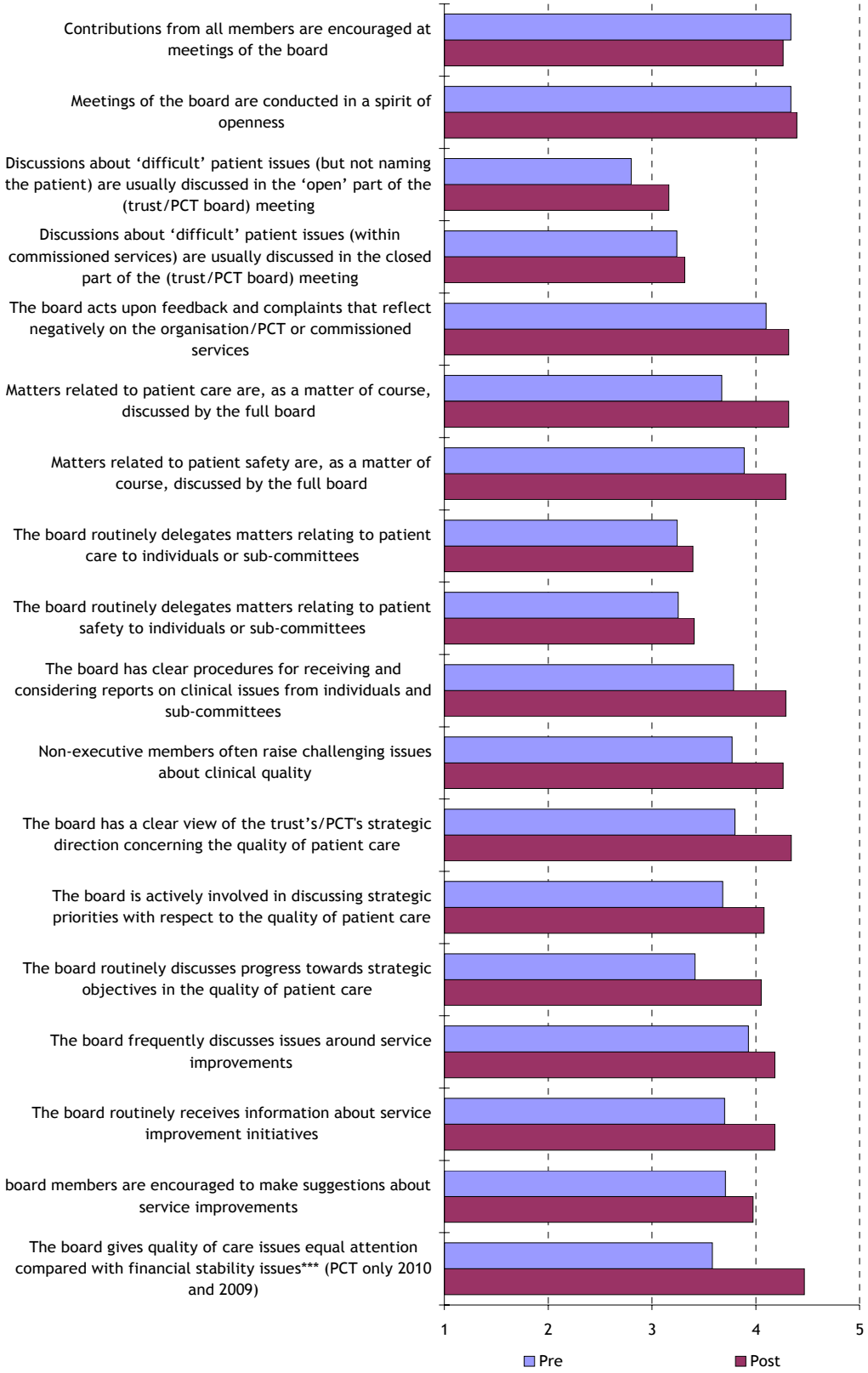
8.4 The working of the board

Respondents were asked their views on the working of the board. Means were also calculated for each statement relating to the working of the board; these are displayed in Figure 8.4.

Figure 8.4 shows that 17 out of 18 items demonstrate rises/improvements in perceptions. The exception is the first item 'contributions from all members are encouraged at meetings of the board', where there was a slight fall in mean score, although this was from a high starting point.

The largest increase in mean value since the pre-programme survey relates to a PCT-only statement, 'The board gives quality of care issues equal attention compared with financial stability issues', showing a rise from 3.58 pre-programme to 4.47 post-programme – indicating an increase in levels of agreement with this item among PCT respondents.

Figure 8.4: The working of the board, mean values



Notes: *** PCT only statement

Source: IES pre- and post-programme survey, 2009 and 2010

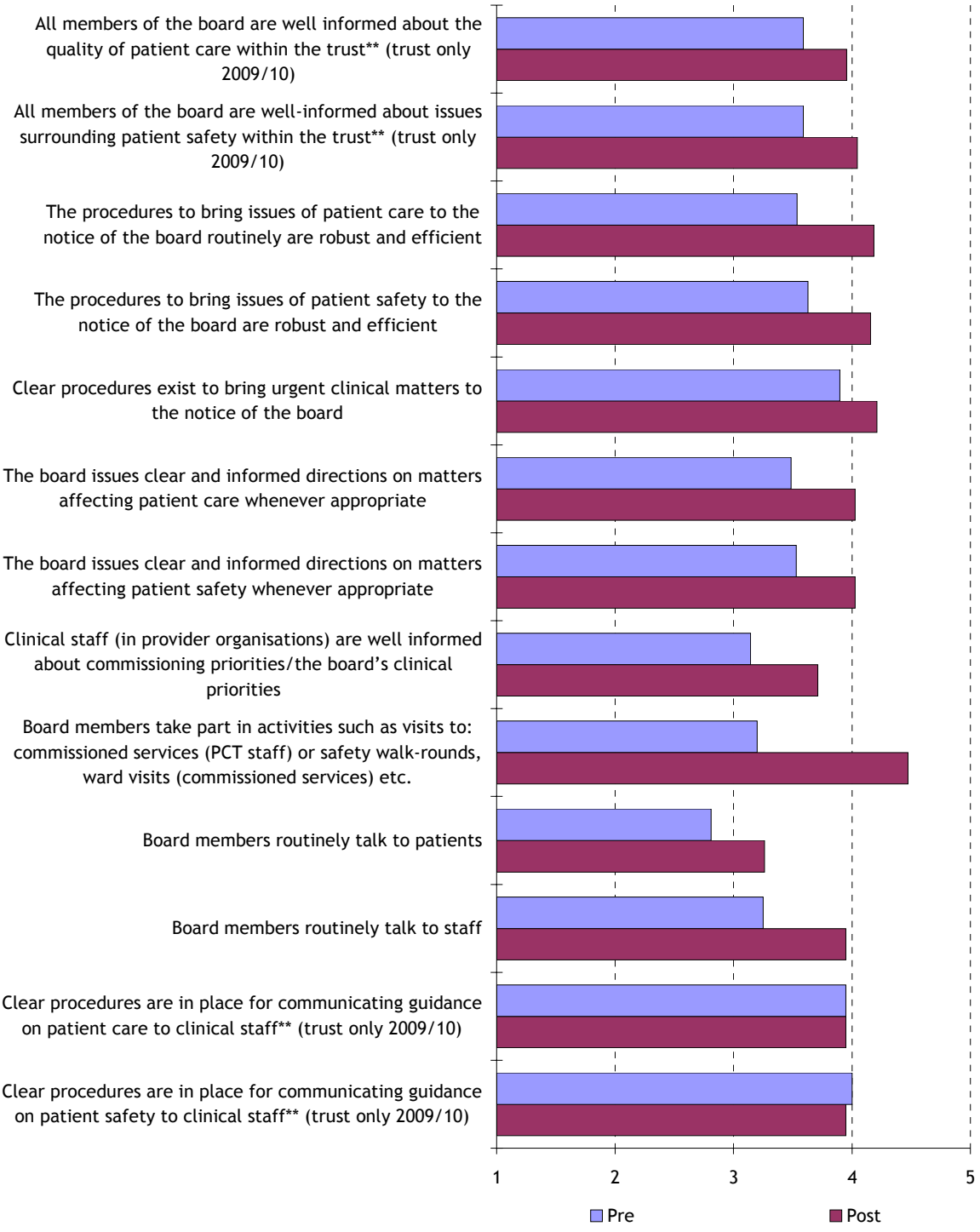
Appendix Table A2.4 provides more detail on the eighteen statements comprising the working of the board items. Highlights include the following:

- Ninety-four per cent of pre-programme respondents agreed that contributions from all members are encouraged at meetings of the board. This fell to 89.5 per cent post-programme, related to a small increase in the proportion of respondents who disagreed with the statement.
- Nearly all pre- and post-programme respondents agreed that meetings of the board are conducted in a spirit of openness (pre: 95.7 per cent, post: 97.4 per cent).
- Just less than half of pre-programme respondents agreed that the board routinely delegates matters relating to patient care or patient safety to individuals or sub-committees. This rose to over 60 per cent of respondents post-programme.
- Nearly half of pre-programme respondents disagreed that discussions about 'difficult' patient issues (but not naming the patient) are usually discussed in the 'open' part of the meeting (45.7 per cent). This figure halved post-programme to 21.6 per cent.
- Just under a quarter of pre-programme PCT respondents disagreed that the board gives quality of care issues equal attention compared with financial stability issues. No PCT respondents disagreed with this statement post-programme.

8.5 Communication and the board

Respondents were asked their views on communication and the board. Means were calculated for each statement relating to communication and the board; these are shown in Figure 8.5.

Figure 8.5: Communication and the board, mean values



Notes: ** Trust only statement

Source: IES pre- and post-programme survey, 2009 and 2010

The most notable change in mean scores relates to the statement 'Board members take part in activities such as visits to: commissioned services (PCT staff) or safety walk-rounds, ward visits (commissioned services) *etc.*' – a rise from 3.20 pre-

programme to 4.47 post-programme, indicating an increase in agreement with this item.

The mean values for 11 out of 13 items have risen; one has stayed the same and one has slightly declined in levels of agreement in provider organisation respondents with the statement 'Clear procedures are in place for communicating guidance on patient safety to clinical staff' – falling only slightly from 4.00 pre-programme to 3.95 post-programme.

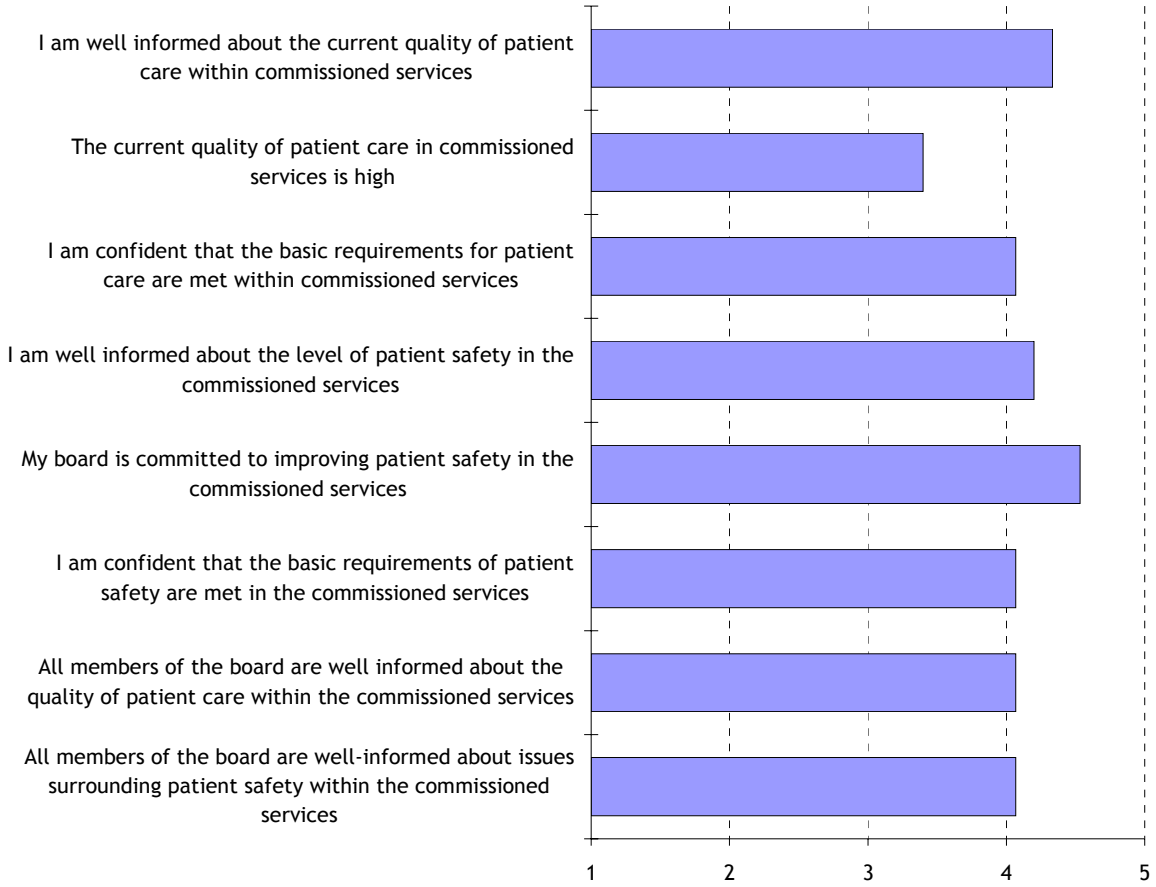
Appendix Table A2.5 provides more details on the ratings for the 13 statements which comprise the communication and the board category. Highlights include the following:

- Just over half of pre-programme respondents (58 per cent) agreed that the procedures to bring issues of patient care to the notice of the board routinely are robust and efficient. This rose to 89.4 per cent post-programme.
- Seventy-one per cent of pre-programme respondents agreed that clear procedures exist to bring urgent clinical matters to the notice of the board. This compares with 86.8 per cent post-programme.
- While just over a quarter of pre-programme respondents disagreed that clinical staff are well informed about the board's clinical priorities, this proportion fell considerably post-programme, with just 2.6 per cent of respondents in disagreement.
- Just over half of pre-programme respondents felt that the board issues clear and informed directions on matters affecting patient care or patient safety whenever appropriate. This compares with just over 80 per cent of respondents to the post-programme survey.

8.6 A snapshot of the views of PCT respondents

The post-programme survey asked several additional questions of PCT respondents to provide an additional snapshot of their views relating to commissioned services and in-house community providers. Figure 8.6 and Figure 8.7 show the mean scores on these items. As with the graphs above, the higher the score the higher the level of agreement with the item. Further breakdowns of responses are shown in Appendix Tables A2.6 and A2.7.

Figure 8.6: Commissioned services, mean values

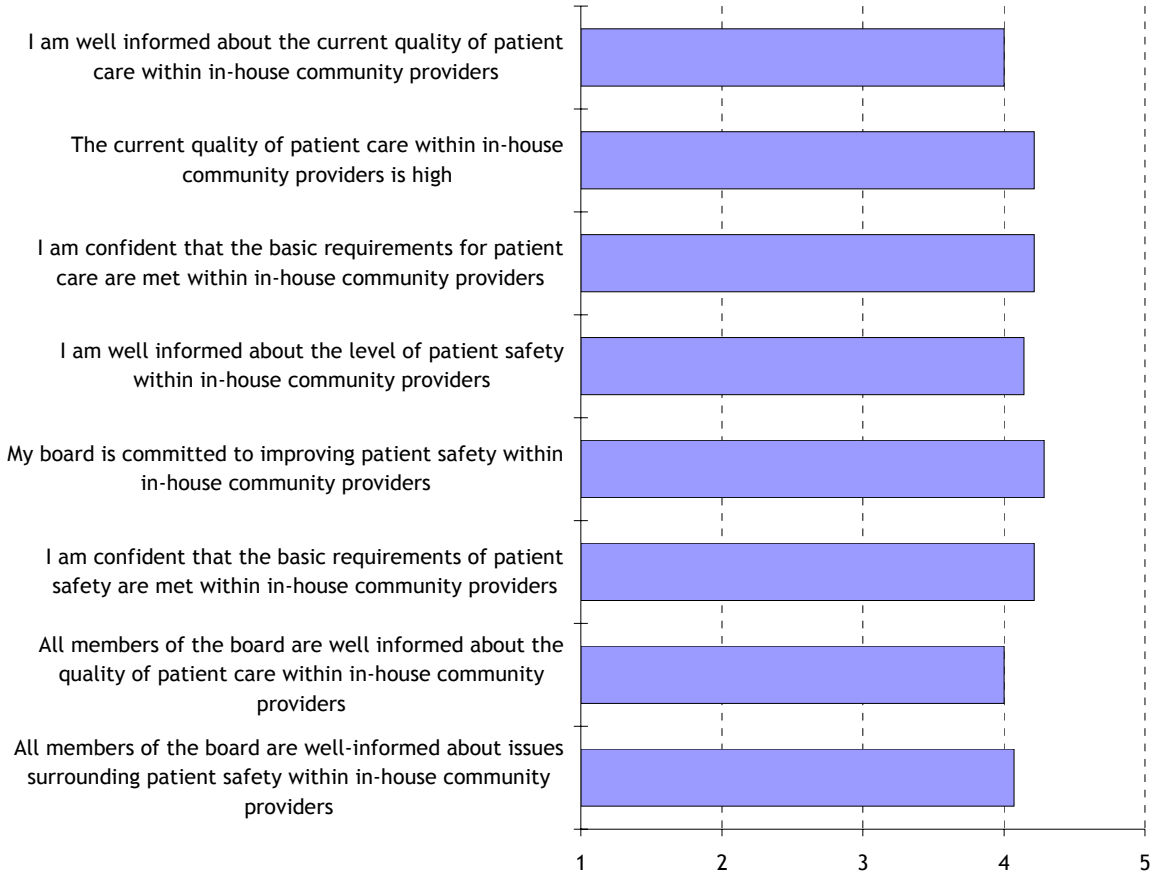


Source: IES, 2010

Figure 8.6 above shows that the highest level of agreement, on average, relates to the statement 'My board is committed to improving patient safety in the commissioned services' (4.5), while the lowest levels of agreement are shown against the statement 'The current quality of patient care in commissioned services is high' (3.4).

As with Figure 8.6, Figure 8.7 shows that the highest levels of agreement relate to the statement 'my board is committed to improving patient safety within in-house community providers' (4.3), while the lowest levels, which nevertheless indicate high levels of agreement overall, relate to the statements 'all members of the board are well informed about the quality of patient care within in-house community providers' (4.0) and 'I am well informed about the current quality of patient care within in-house community providers' (4.0).

Figure 8.7: In-house community providers, mean values



Source: IES, 2010

8.7 Summary of survey findings

This chapter has presented the findings of the pre- and post-programme surveys. It has also shed some light on one of the research questions:

> *Is there any evidence of **changes in levels of clinical engagement** among the boards as a whole following participation in the development programme? Do individual members perceive they have become more clinically 'engaged'?*

Overall the compared results of the pre- and post-programme surveys indicate a clear increase in the clinical engagement of the respondents, with a general rise in the mean level of agreement with each of the measured statements. Mean levels of agreement increased on 47 out of the 55 statements comprising the clinical engagement categories (85 per cent): levels stayed the same on three statements and decreased on five statements. Therefore on average, individual members who responded to our surveys do perceive themselves as more clinically engaged.

The key findings are summarised below:

- Increased confidence and empowerment in nurse directors.

The most commonly reported effect of the programme for the nurse director by post-programme respondents was an increase in the confidence and empowerment of the nurse director, as well as a raising the profile of the nurse director and patient quality and safety issues. This was in line with respondents' pre-programme expectations.

- Rise in the profile of patient safety and quality issues.

Pre-programme respondents most commonly felt that key outcomes of the development programme for the trust/PCT would be an increase in the profile, awareness and understanding of, and focus on, patient care and safety issues by the board. As anticipated by pre-programme respondents, the most commonly cited effect of the programme on the trust/PCT by post-programme respondents was a rise in the profile of patient safety and quality issues in the board and a rise in the profile of the nurse director.

- Rise in discussions about patient care and safety within trusts/PCTs.

Overall there has been a rise in levels of agreement with items relating to respondents' thoughts on patient care and patient safety between the pre- and post-programme surveys. In particular, this relates to trust respondents' level of agreement with the statement 'The current quality of patient care in the trust is high', which shows a rise in the mean score from 3.82 to 4.32 and level of agreement with 'Issues about patient safety are discussed openly within the Trust/PCT' rising from 4.17 to 4.56 on average.

- Board members are more receptive to contributions by the nurse director.

Despite a slight drop in the average level of agreement with the statement 'The contribution made by the nurse director at meetings is not limited to matters of patient care and patient safety', respondents do, on average, agree more post-programme that the board is generally very receptive to points raised by the nurse director about patient care and patient safety and welcomes and considers contributions not directly related to patient care and safety.

- Increase in boards giving equal attention to quality of care and financial issues.

As with other sections of the survey, there is an overall increase in the level of agreement with positive statements relating to the working and the communication of the board. One of the most noteworthy increases is shown in relation to the view that 'Matters related to patient care/patient safety are, as a matter of course, discussed by the full board'.

In addition, agreement by PCT respondents to the post-programme survey to the statement 'The board gives quality of care issues equal attention compared with financial stability issues' has, on average, grown considerably. With regards to communication, respondents appear more agreeable than in the pre-programme survey to the view that 'board members routinely talk to patients' and 'board members routinely talk to staff'.

- PCT respondents feel generally positive about quality within commissioned services and in-house providers.

The post-programme survey asked several additional questions of PCT respondents on commissioned services and/or in-house community providers in order to provide a snapshot of their views. The results generally painted a positive picture – with all mean scores achieving four or above. Respondents generally felt well-informed about the current quality of patient care within commissioned services and in-house community providers, and generally took the view that the board is committed to improving patient safety in commissioned services and in in-house community providers.

In this chapter we completed our presentation of the analyses and findings from our evaluation study. In the next chapter we present our conclusions and discuss the implications for research and practice, especially in the context of the proposed NHS reorganisation.

9 Conclusions and Implications

In this final chapter we draw together the findings from the various analyses in presenting our conclusions from this evaluation study in the context of the original research questions posed by our study sponsors. We then also outline some of the implications of the study for research and practice, especially in the context of the proposed reorganisation and 'new NHS'.

Our research questions were:

- How **rich is the dialogue about clinical issues** in boardroom conversations and is there any evidence that dialogue changes following the programme's interventions?
- How does the way a board operates influence the nature of the **conversations about clinical issues**?
- Is there any evidence of **changes in levels of clinical engagement** among the boards as a whole following participation in the development programme? Do individual members perceive they have become more 'clinically engaged'?

9.1 Evidence of positive changes in perceptions of clinical engagement

In seeking to answer the research questions, we start in this first section by identifying whether there was an improvement in board members' perceptions of the patient care agenda and their willingness to engage with clinical issues. In Chapter 8 we reported that there was indeed a marked increase in board member perceptions about their own level of clinical engagement and the profile of patient safety and quality issues within their board, as identified through a general rise in the mean level of agreement with the vast majority of the measured statements in our surveys. The findings from analysing the roles of the board members in trust

meetings in Chapter 6 shed more light on how the increase in the profile of the issues worked in practice:

- Board meetings have become longer (in one trust this was due to more reporting of clinical issues while in another trust everything was being discussed more fully).
- Board members with clinical responsibilities have increased their contributions.
- Board members are more receptive to contributions by the nurse director.
- PCT board members perceive they now give equal attention to quality of care and financial issues.
- The chair's style is key.

9.2 Illustrations of more effective board conversations about clinical issues

The observed trust board meetings reported in Chapters 2–6 discussed the care quality and patient safety agenda in its pre-allocated slot within the board meeting agenda. This agenda circulated beforehand constitutes the backbone of each discussion and sets out, to a certain extent, the institutional rules by which items are to be discussed (when they should be raised, by whom and how). We showed how one of the trusts, by placing items on clinical issues early on in its , helped to improve the time spent (reported in Chapter 3) and the quality of the engagement on the clinical agenda during its post-programme meeting (reported in Chapter 5). It is also important, though, for clinical items to be introduced by the chair in ways that do not bias members as to how much they should request and offer assurances. Neither should feedback be sought using leading questions such as 'Are you happy with it?'

We showed (in Chapter 4) how a topic can be introduced as a clinical one (eg, medical director talks about adopting a clinical perspective for an IT problem). However, whether or not an item on the agenda will be discussed *from a clinical perspective* depends on other members' actions. NEDs' turns in conversation often challenge and scrutinise, consistent with their role on the board. NEDs, therefore, play a particularly important role in steering the discussion of the issues raised. In one sequence we showed how a NED's challenging questions led to defensive answers and steered the discussion about IT problems away *from a clinical perspective*.

In one of the post-programme board meetings reported (in Chapter 5), one of the non-executives also acted as vice chair. This worked well as the non-executive intervened to remind members to discuss patient complaints. The chief executive

also demonstrated an interest in getting to the heart of the problem from early on in the discussion. The result was a relatively lengthy conversation among a few executives and non-executives. Encouraging members to 'see positive aspects' and probing into what happens in other organisations were practices that resulted in constructing patient complaints as inherently negative stories about an organisation and thus directing the board's engagement away from discussing accountability and finding solutions to issues particular to their organisation. Trust boards' capabilities to engage with sensitive clinical issues increase when those in more 'powerful' roles show commitment to discussing such issues, when members do not constantly seek success stories and when they focus on what happens within the organisation instead of across other organisations.

In the same way that trust board members should not shy away from discussing patient complaints, highlighting risk to clinical services could also serve to strengthen arguments for new and improved services. Equally, discussing patient care policies brings up complex moral issues; the importance of these issues should be acknowledged if board members, particularly non-executives, are to have an in-depth understanding and engage with the business of the trust.

Our analysis of the board meeting discussions showed the nurse executives raising items and answering questions with more confidence in the post-programme meetings (including in some sequences reported in Chapter 5). This was particularly the case when describing organisational processes such as those around monitoring performance. A recurrent pattern we observed, however, was that they had trouble bringing the patient voices into the boardroom. We feel this is a really important point – until boards start seeing things from the patient's perspective, are they really going to tackle safety and quality issues convincingly? In an evidence-based culture, where the quantification is favoured, patient stories are treated as inferior and biased evidence. Boards need to be persuaded of the importance of such stories and nurse executives need to be further helped in that respect.

9.3 Did the development programme 'work'?

As previously stated, we have identified a large number of changes in perceptions about clinical issues through our surveys and the majority of these can be described as improvements. The West Midlands SHA may feel that this justifies the investment and time spent in the development programme. However, our research cannot say that the Burdett Board development programme 'worked' as that was not a question we set out to answer. Our study has focused on outcomes by collecting evidence of 'what' changes in perceptions and behaviour occurred during the period of participation in and shortly after the development programme and what the nature of such changes appeared to be. We did not

make any attempt to show causality and hence cannot say that any changes were directly or indirectly as a result of the programme. Other national and local initiatives happening at the same time may also have had an impact.

The programme consultants claim (Machell et al., 2010) that, in the 2009/10 cohort we evaluated, the programme achieved:

- significant improvements in the performance of chairs in terms of facilitation and focus
- greater engagement and constructive challenge by NEDs
- more focused and confident interventions by nurse executives.

Our study findings would tend to support these claims, especially greater confidence of nurse executives in raising items and answering questions in pursuing clinical care issues. In addition, our evidence shows that during the period of the programme and shortly afterwards, there were:

- increased levels of clinical engagement self-reported by board members
- greater receptiveness of board members to issues raised by nurse executives
- more use of clinical-related language, in some cases.

What our study also does is add to the body of knowledge on NHS board effectiveness and the engagement of (mostly non-clinical) board members with patient care issues. Previously there have only been a small number of detailed empirical studies of what boards do in practice and how they take account of clinical issues (Abbott et al., 2008; Mueller et al., 2004; Burdett Trust, 2006) and these have tended to show that boards are more likely to focus on a narrow range of finance-related matters at the expense of clinical quality. Our study adds to these by exploring the nature of conversations in the boardroom, and provides some illustrations of how the behaviour and interactions between key players and board-operating processes can affect the quantity and quality of discussions about clinical issues in the boardroom.

9.4 Sense making about the clinical engagement of boards

As we have shown throughout this report, a board meeting is not an easy place to raise or discuss quality of care issues. Many factors in combination can result in a limit to the time available.

Board etiquette creates a discursive space for people to make certain contributions and in certain ways while avoiding others. There are institutional rules dictating

the order and type of contributions by each member in the board. The chair's contributions aim to moderate the flow of the interaction, to make requests, to facilitate the discussion, to open and close a discussion, to ensure that board members receive satisfactory information from others, to achieve consensus among board members, and to make decisions about next steps. One of the most important purposes in these meetings is to challenge and interrogate board members and this role is allocated to NEDs. As we saw in Chapters 4 and 5, their contributions were very important in steering the debate on an issue raised towards either its clinical or non-clinical implications. However, members orientate differently to these institutional rules depending on the occasion.

Members of the board are 'doing things together' such as co-constructing the essence of a matter, attributing blame, building consensus, or even working towards the completion of the agenda within the time allocated. Board members discuss clinical issues in the course of performing these activities. So, for example, there may be more serious implications for how extensively a patient-related issue will be discussed if it is scheduled towards the end of the agenda when time pressures are greater or if the discussants attempt to undermine the authority of a speaker.

The board meeting takes place in the context of a set of written documents (an agenda and individual reports) which has been circulated among members; all participants are expected to have read these documents and bring this knowledge into the boardroom. Clinical issues are not introduced in the boardroom but they are initially presented to members – or at least this is the assumption – in the form of written documents prior to the meeting. Attention has to be paid, therefore, to the content and title of these papers, which may serve to communicate in more detail patient-related issues.

How issues in the agenda are raised by the designated speaker is also important. For clinical issues to be effectively discussed by the board, they need to be raised in such a way as to invite the dialogue rather than *just* be reports of progress, performance, *etc.* In that regard the nurse executive can play an important role. There are power asymmetries within the board, however. The chair and the non-executives have more power to encourage or discourage a topic of conversation, than any other person. They need to show an equal interest in clinical issues. The nurse directors at each of our three board meeting analysis sites showed dedication in their efforts to help the boards improve their leadership and management of the quality and safety agenda. But our analysis showed that they alone cannot make this happen by bringing an issue to the board. A level of clinical engagement of others is needed in order to allow the space for the issue to be discussed.

9.5 Implications for research

IES is excited about the findings from the research so far. We believe specific occurrences found from our micro-practice research will make a valuable addition to the body of knowledge in the fields of:

- methods in leadership research
- board member development
- patient quality, safety and experience.

9.5.1 Methods in leadership research

We are not the first to introduce a research approach where groups of directors or managers have been captured interacting with each other on audio or video tape recordings. What is different has been introducing this approach to multiple NHS board meetings over two time periods. It represents a shift away from the more common qualitative approach of *asking* board members questions during in-depth interviews to *seeing* and *hearing* them operate in the boardroom over a period of time. When we undertake such research what we primarily hear is directors and senior managers talking to each other. We adapted the theoretical and methodological approaches taken from conversation analysis and discursive psychology of the micro-practices that characterise pair processes in a work setting for use on group processes in the board meetings. We suggest that a micro-practice study of board members' conversational patterns, a focus on *what* they are actually talking about and *how* relevant knowledge and/or experience are deployed to influence boardroom process is a useful contribution to a researcher's options.

In this evaluation report our principal objective is evaluative: to identify any changes in behaviour and attitudes among board members and analyse the talk-based routines in board meeting conversations. In addition a supplementary objective has been to demonstrate the usefulness of a multi-methods approach to leadership research which includes a micro-practice ethnographic-type focus upon talk-based routines in the boardroom. In doing this we have outlined in earlier chapters our theoretical and analytical infrastructure drawn from multiple disciplines; explained our application process and its limitations; and reproduced illustrative extracts of real boardroom talk to add to that presented by other researchers to show what this data 'looks like'. We hope that this will encourage other researchers to embrace conversation-style analysis and other emerging alternative methods (eg narrative enquiry) to researching what goes on behind boardroom doors.

9.5.2 Researching patient quality, safety and experience

It is not hard to envisage how the changes proposed for the NHS and the disruption while they are being implemented and embedded, might impact negatively on clinical quality. While the evidence base is growing on how current boards can assure the quality of patient care and their delivery of it, we don't know how this primary duty of an NHS board will be affected by the turbulent times ahead. Existing guidance on how to develop safe and effective services tends to be written with stable organisations in mind. Further research will be needed to generate data and guidance on how best organisations can balance the quality agenda with staff leaving and services reorganising. The questions needing investigation include the following:

- 'How can NHS organisations keep patient quality central to corporate agendas where services and organisations are being closed, radically changed or likely to come under intense pressure?'
- 'How are organisations making the savings and what is the impact on patient experience?'
- 'What additional skills will GP consortia boards need to be able to articulate the required quality standards or the impact of gaps in service quality?'

We were pleased to hear the development of a practical tool already taking place in the West Midlands. NHS West Midlands is leading work nationally on how the NHS can maintain a focus on quality and safety during the transition. During the period of our evaluation study of Cohort 1 of the Burdett Trust programme in the West Midlands, a second cohort of five more organisations also completed the programme (March 2010 – February 2011) and a third cohort has commenced. The King's Fund has undertaken a literature review (as yet unpublished) on organisations during upheaval to identify strategies to help boards. They have also developed a series of checklists that they are testing and refining with Cohort 3, whose participating organisations include merged PCTs in new cluster arrangements, with the objective of helping anchor a board's attention to quality.

IES would also like to see research into how organisations in the independent health sector undertake their patient safety assurance and keep a focus on quality. This is especially important in the context of their different corporate governance arrangements. As well as identifying if their systems and practices work (and how they work), this will be important in reassuring new NHS commissioners who may come under pressure to justify increasingly larger investments in apparently cheaper independently provided services.

9.5.3 Board development

Boards play a crucial role in ensuring that NHS organisations are publicly accountable and perform well. Serious questions have been raised about the ability of boards to govern effectively following various failures, eg at Stafford Hospital. This study adds to the literature about what current NHS boards do in practice and how they take account of clinical issues. But what of new commissioning boards in the future?

There is some concern over the few governance rules apparently being applied to GP consortia. IES would welcome research examining the intended and unintended outcomes of the new arrangements in the NHS. It is important to follow how the new cluster boards and GP consortia have developed and whether they are proving to be effective commissioners. If GP consortia are taking over the majority of the NHS budget, how are they doing and what has the impact been on costs, clinical quality and governance? Have the new boards been able to overcome current governance tensions identified by Storey et al. (2010) between competition and collaboration, and between autonomy and hierarchical direction?

9.6 Implications for practice

Particular attention in the Burdett Trust programme is given to the interplay between the board and the nurse executive because, as leaders of the largest part of the health workforce, nurse executives have unrivalled influence over patients' experiences of care. This, combined with a broad portfolio of responsibilities that usually include quality and governance, the programme deliverers state makes the nurse executive role vital in bridging the link between the patient bedside and the boardroom. Certainly the nurse executives we recorded shared with their boards an understanding of the standard of clinical care provided or commissioned by the organisation. We concluded above that when it comes to clinical quality, nurse executives alone cannot make for an effective board. The Burdett Trust programme helped the eight trusts who completed their programme. But what does this tell us that may be useful to other NHS organisations without the benefit of this or similar programmes? In this section we address the implications for practice.

9.6.1 Effectiveness of existing NHS boards

In The King's Fund report of the programme, '*Dilemmas in bringing the ward to the board*', the consultants to the eight trust boards who completed the programme have set out many of the dilemmas they believe get in the way of boards effectively engaging with the business of caring. In doing so they have already provided much of the material from which others can learn and we hope that

wide dissemination of this practical advice takes place. In terms of further development, The King's Fund consultants recommend:

- focusing board development interventions on the chair (and deputy chair)
- developing an orientation around quality assurance and quality improvement for NEDs, including skilling up in data literacy and analysis
- facilitating stronger collaboration between nurse executives and medical directors and developing their potential to bring a cohesive voice to their boards in quality and shared responsibility for this challenging agenda.

In addition to these recommendations IES would suggest:

- whole board development, which might include:
  - engaging with examples of impact which we have provided through our research, so that all members can better understand and reflect on their role in conversations about clinical issues
  - observation and feedback from an external coach/facilitator on own board's behaviours and culture, so that mindsets can be challenged and reassurance for the board given on whether they are doing 'the right things' when it comes to quality.
- briefings to chairs on the effect and importance of practical issues such as the positioning of clinical items on the agenda, and their own response and reactions to contributions from others.

9.6.2 Board effectiveness beyond the NHS

There are also lessons to be learnt for other sectors beyond health. Board effectiveness is a source of great concern elsewhere too, especially currently in the finance sector. IES is aware that the revised Corporate Governance Code was introduced by the Financial Reporting Council for quoted companies in 2010. The code sets out principles relating to the role and effectiveness of boards, encourages chairs to report personally in annual reports how these principles have been applied, and advises that 'the board should undertake a formal and rigorous annual evaluation of its own performance and that of its committee and of individual directors', setting out how this has been done in the annual report. The code also includes a new provision that 'evaluation of the board of FTSE 350 companies should be externally facilitated at least every three years'. It stresses that achieving a high-performing board is 'a challenge that should not be underrated' as 'to run a corporate board successfully is extremely demanding', depending on factors such as good leadership by the chair and 'the frankness and openness of mind' with which issues are discussed.

The corporate governance code sets out seven aspects of board effectiveness, such as the balance of skills of board members and the need for adequate induction of them, as well as good governance principles in four other areas, such as leadership and remuneration. Some areas would be relatively straightforward to assess compliance in 'tick box' fashion, for example the structure and composition of the board and its committees, the length of service and independence of NEDs, the use of rigorous selection procedures etc, and many providers will undoubtedly come forward with tick box solutions. Other aspects, however, such as the quality and openness of debate and the personal contribution of each director, are more complex and would undoubtedly benefit from the type of qualitative assessment used in this study. There is much that can be learnt from our study in terms of what powerful feedback you can get from a conversation-style analysis of a board meeting, if conducted and followed through in the spirit of personal and whole board development. We would suggest these FTSE350 companies when considering any board effectiveness evaluation should ensure it includes some methodology for recording, analysis and feedback of a board meeting and key committees to identify areas for improvement.

9.6.3 Within the context of the 'new' NHS

The proposed reorganisation is like no other in the history of the NHS. The pace and scale of the change is unprecedented. The government-planned reforms are set out in 'Equity and Excellence: Liberating the NHS' (at second stage parliamentary reading at the time of writing this report). The key points at the time of writing are as follows:

- During this change organisations need to continue to deliver on Quality, Finance and Performance as well as make the required savings of £15–20 billion.
- The £15–20 billion savings are to reinvest in improving quality and outcomes.
- This will not happen without clarity and focus on delivery at every point in the health system.
- There is a to be a big emphasis on patient-led service, local empowerment, clinical leadership and a sustained focus on improving outcomes.
- Only by driving quality and productivity together can the required savings be realised by 2013/14 to reinvest in meeting increasing demand and patient expectations. This is why Quality, Innovation, Productivity and Partnership (QIPP) have been, and will continue to be, of central importance.

There is the potential for quality and patient safety to be compromised during transition. The West Midlands SHA CEO is leading the work nationally for David

Nicholson on quality and a document is planned as an addendum to the Early Warning document that was published last year following the Robert Francis Enquiry into Mid Staffs'. There will certainly be a move to ensure that all provider organisations can demonstrate due diligence on quality. The new Care Quality Commission and Monitor roles will also be very different, with the CQC having the power to remove licences. Non-executive directors will have to be very well versed in the quality of care issues in their organisations so that they can hold the executives to account.

Our understanding is that from June 2011 in the West Midlands there will be a single executive team for each cluster board of merged PCT groups and they will have a two-year remit. Responsibility for patient safety and quality will rest with cluster boards while GP consortia are being set up and developed. Consortia will have delegated budgets from April and may develop to take on complete responsibility for the commissioning agenda. Advice from those involved in our evaluation suggests the need for these newly forming organisational entities to focus on the right membership of the cluster boards and GP consortia, including:

- a specific person to lead on quality (doesn't have to be a nurse);
- use of standardised information and reports to GP consortia boards to tell them what's going on in a consistent fashion;
- embracing a level of external scrutiny in GP consortia (doesn't have to be a non-executive, a patient organisation representative might also work);
- take time out as a board at some point during the first six months to focus on quality, the patient experience and how this feeds into your board's collective decision making.

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Appendix 2: Survey Tables

Respondents were asked to state their level of agreement/disagreement with a series of statements using a 5-point scale (1=strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree: this scale relates to the x-axis in Figures 8.1 to 8.4). The section contains a mix of positively and negatively worded statements. For the purposes of analysis and presentation, the scores for negatively worded statements have been reversed. This enables high scores to indicate satisfaction, and low scores dissatisfaction, consistently throughout the report. The affected statements are identified by a single asterisk.

Several statements were only appropriate for respondents from provider organisations and not primary care trusts (PCTs) or vice versa. Such statements are shown clearly as being 'trusts only' (data from the four PCTs is excluded) or PCTs only (data from provider organisations is excluded). The affected statements are identified by a double or triple asterisk respectively.

Appendix Table A2.1: Your thoughts on patient care, percentage

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
I am well informed about the current quality of patient care within the trust** (trust only 2009/10)	0	0	2.6	0	12.8	0	59	86.4	25.6	13.6
I have confidence in the information I receive from official sources about issues surrounding the quality of patient care (in provider	0	0	9.9	5.3	16.9	5.3	62	71.1	11.3	18.4

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
organisations which the PCT has commissioned)										
My knowledge of the current level of quality of patient care (in provider organisations) is not mostly informed by my 'informal network'*	1.4	2.6	19.7	2.6	26.8	26.3	46.5	63.2	5.6	5.3
The information I receive from my informal network about patient care (in provider organisations) is reliable	0	2.6	8.5	15.8	46.5	44.7	45.1	31.6	0	5.3
Issues surrounding patient care (in provider organisations) are discussed openly within the trust/PCT	0	2.6	1.4	0	9.9	2.6	59.2	34.2	29.6	60.5
The current quality of patient care in the trust is high** (trust only 2009/10)	0	0	2.6	0	28.2	0	53.8	68.2	15.4	31.8
I am confident that the basic requirements for patient care are met at the trust** (trust only 2009/10)	0	0	5.1	0	20.5	0	48.7	72.7	25.6	27.3
Care of patients is the trust's/PCT's top priority	0	2.6	4.2	2.6	8.5	2.6	45.1	31.6	42.3	60.5
Senior managers in this trust/PCT are committed to patient care	0	2.6	2.8	0	8.5	5.3	45.1	31.6	43.7	60.5
Understanding the experience of healthcare from patients and carers is an important part of commissioning care*** (PCT only 2009/10)	0	0	0	0	0	0	21.9	6.7	78.1	93.3

Source: IES pre- and post-programme surveys, 2009 and 2010

Appendix Table A2.2: Your thoughts on patient safety, percentage

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
I am well informed about the level of patient safety in the trust** (trust only 2009/10)	0	0	2.6	0	12.8	0	53.8	86.4	30.8	13.6
My Board is committed to improving patient safety in the trust** (trust only 2009/10)	0	0	0	0	7.7	0	46.2	36.4	46.2	63.6
I have confidence in the information I receive from official sources concerning patient safety	0	0	4.2	2.6	19.7	5.3	60.6	76.3	15.5	15.8
My knowledge of issues surrounding patient safety is not mostly acquired by my 'informal network'*	0	2.6	15.5	2.6	32.4	36.8	46.5	52.6	5.6	5.3
Issues about patient safety are discussed openly within the trust/PCT	0	0	0	0	11.4	0	60	40.5	28.6	59.5
The level of concern about patient safety in the trust is high/in provider organisations is of high interest to the PCT as a commissioner	0	0	4.3	2.7	12.9	8.1	52.9	29.7	30	59.5
The current level of commitment (at the PCT) to improving patient safety in providers is high/throughout the trust is high	0	0	1.4	0	12.7	2.6	47.9	36.8	38	60.5
I am confident that the basic requirements for patient safety are met in the trust** (trust only 2009/10)	0	0	2.6	0	15.4	0	59	63.6	23.1	36.4
The trust/PCT welcomes patient feedback	0	0	0	0	8.6	5.4	52.9	32.4	38.6	62.2
The trust/PCT takes action to improve patient safety/patient outcomes	0	0	0	2.7	0	2.7	55.7	43.2	44.3	51.4

Source: IES pre- and post-programme surveys, 2009 and 2010

Appendix Table A2.3: The role of the nurse director, percentage

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
The contribution made by the nurse director at meetings is not limited to matters of patient care and patient safety*	0	5.3	5.7	5.3	5.7	10.5	51.4	44.7	37.1	34.2
The board is generally very receptive to points raised by the nurse director about patient care and patient safety	0	0	0	0	5.7	0	52.9	39.5	41.4	60.5
The nurse director contributes widely to the business of the board including matters not related to patient care or safety	0	0	2.9	5.3	15.7	5.3	40	44.7	41.4	44.7
The board welcomes and considers contributions not directly related to patient care and safety from the nurse director	0	0	0	0	11.4	2.6	48.6	55.3	40	42.1

Source: IES pre- and post-programme surveys, 2009 and 2010

Appendix Table A2.4: The working of the board, percentage

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Contributions from all members are encouraged at meetings of the board	0	0	1.4	2.6	4.2	7.9	53.5	50.0	40.8	39.5
Meetings of the board are conducted in a spirit of openness	0	0	1.4	0	2.8	2.6	56.3	55.3	39.4	42.1
Discussions about 'difficult' patient issues (but not naming the patient) are usually discussed in the 'open' part of the (trust/PCT board) meeting	4.3	0	41.4	21.6	27.1	45.9	24.3	27.0	2.9	5.4
Discussions about 'difficult' patient issues (within commissioned services) are	4.2	5.3	22.5	15.8	21.1	21.1	49.3	57.9	2.8	0.0

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
usually discussed in the closed part of the (trust/PCT board) meeting										
The board acts upon feedback and complaints that reflect negatively on the organisation/PCT or commissioned services	0	0	4.2	0	5.6	7.9	66.2	52.6	23.9	39.5
Matters related to patient care are, as a matter of course, discussed by the full board	0	0	11.4	0	21.4	7.9	55.7	52.6	11.4	39.5
Matters related to patient safety are, as a matter of course, discussed by the full Board	0	0	7	0	15.5	5.3	59.2	60.5	18.3	34.2
The board routinely delegates matters relating to patient care to individuals or sub-committees	1.4	0	18.6	26.3	35.7	13.2	42.9	55.3	1.4	5.3
The board routinely delegates matters relating to patient safety to individuals or sub-committees	1.4	0	20	27.0	34.3	10.8	42.9	56.8	2.9	5.4
The board has clear procedures for receiving and considering reports on clinical issues from individuals and sub-committees	0	0	10	2.6	17.1	5.3	57.1	52.6	15.7	39.5
Non-executive members often raise challenging issues about clinical quality	1.4	0	10	2.6	20	5.3	47.1	55.3	21.4	36.8
The board has a clear view of the trust's/PCT's strategic direction concerning the quality of patient care	0	0	10	0	18.6	5.3	52.9	55.3	18.6	39.5
The board is actively involved in discussing strategic priorities with respect to the quality of patient care	0	0	11.4	2.6	18.6	15.8	58.6	52.6	10	28.9
The board routinely discusses progress towards strategic objectives in the	0	0	17.1	2.6	30	15.8	47.1	55.3	5.7	26.3

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
quality of patient care										
The board frequently discusses issues around service improvements	0	0	8.6	2.6	8.6	7.9	64.3	57.9	18.6	31.6
The board routinely receives information about service improvement initiatives	0	0	15.7	2.6	14.3	10.5	54.3	52.6	15.7	34.2
Board members are encouraged to make suggestions about service improvements	0	0	8.6	2.7	24.3	16.2	51.4	62.2	12.9	18.9
The board gives quality of care issues equal attention compared with financial stability issues*** (PCT only 2010 and 2009)	0	0	22.6	0	9.7	6.7	54.8	40.0	12.9	53.3

Source: IES pre- and post-programme surveys, 2009 and 2010

Appendix Table A2.5: Communication and the board, percentage

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
All members of the board are well informed about the quality of patient care within the trust** (Trust only 2009/10)	0	0	15.4	0	15.4	13.6	64.1	77.3	5.1	9.1
All members of the board are well-informed about issues surrounding patient safety within the trust** (trust only 2009/10)	0	0	17.9	0	17.9	13.6	51.3	68.2	12.8	18.2
The procedures to bring issues of patient care to the notice of the board routinely are robust and efficient	0	0	10.1	0.0	31.9	10.5	52.2	60.5	5.8	28.9
The procedures to bring issues of patient safety to the notice of the board are robust and efficient	0	0	10	0.0	24.3	13.2	58.6	57.9	7.1	28.9

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Clear procedures exist to bring urgent clinical matters to the notice of the board	0	0	5.8	0.0	23.2	13.2	46.4	52.6	24.6	34.2
The board issues clear and informed directions on matters affecting patient care whenever appropriate	1.4	0	10	0.0	32.9	15.8	50	65.8	5.7	18.4
The board issues clear and informed directions on matters affecting patient safety whenever appropriate	1.4	0	8.6	0.0	31.4	18.4	52.9	60.5	5.7	21.1
Clinical staff (in provider organisations) are well informed about commissioning priorities/the board's clinical priorities	1.4	0	24.6	2.6	36.2	34.2	33.3	52.6	4.3	10.5
Board members take part in activities such as visits to commissioned services (PCT staff) or safety walk-rounds and ward visits (commissioned services) *etc.*	8.6	0	21.4	0.0	20	0.0	41.4	43.5	8.6	56.5
Board members routinely talk to patients	10.1	0	30.4	34.8	30.4	30.4	26.1	21.7	2.9	13.0
Board members routinely talk to staff	7.4	0	19.1	4.3	23.5	8.7	41.2	56.5	8.8	30.4
Clear procedures are in place for communicating guidance on patient care to clinical staff** (trust only 2009/10)	0	0	0	4.5	23.1	13.6	59	63.6	17.9	18.2
Clear procedures are in place for communicating guidance on patient safety to clinical staff** (trust only 2009/10)	0	0	0	4.5	17.9	13.6	64.1	63.6	17.9	18.2

Source: IES pre- and post-programme surveys, 2009 and 2010

Appendix Table A2.6: Commissioned services (PCT only 2010), percentage

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	Post	Post	Post	Post	Post
I am well informed about the current quality of patient care within commissioned services	0.0	0.0	0.0	66.7	33.3
The current quality of patient care in commissioned services is high	0.0	0.0	60.0	40.0	0.0
I am confident that the basic requirements for patient care are met within commissioned services	0.0	0.0	0.0	93.3	6.7
I am well informed about the level of patient safety in the commissioned services	0.0	0.0	13.3	53.3	33.3
My board is committed to improving patient safety in the commissioned services	0.0	0.0	0.0	46.7	53.3
I am confident that the basic requirements for patient safety are met in the commissioned services	0.0	0.0	6.7	80.0	13.3
All members of the board are well informed about the quality of patient care within the commissioned services	0.0	0.0	20.0	53.3	26.7
All members of the board are well-informed about issues surrounding patient safety within the commissioned services	0.0	0.0	20.0	53.3	26.7

Source: IES post-programme survey, 2010

Appendix Table A2.7: In-house community providers (PCT only 2010), percentage

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	Post	Post	Post	Post	Post
I am well informed about the current quality of patient care within in-house community providers	0.0	0.0	14.3	71.4	14.3
The current quality of patient care within in-house community providers is high	0.0	0.0	7.1	64.3	28.6
I am confident that the basic requirements for patient care are met within in-house community providers	0.0	0.0	7.1	64.3	28.6
I am well informed about the level of patient safety within in-house community providers	0.0	0.0	14.3	57.1	28.6
My board is committed to improving patient safety within in-house community providers	0.0	0.0	7.1	57.1	35.7
I am confident that the basic requirements of patient safety are met within in-house community providers	0.0	0.0	7.1	64.3	28.6
All members of the board are well informed about the quality of patient care within in-house community providers	0.0	0.0	14.3	71.4	14.3
All members of the board are well-informed about issues surrounding patient safety within in-house community providers	0.0	0.0	14.3	64.3	21.4

Source: IES post-programme survey, 2010

Appendix 3: Information and Consent Form

We are seeking your consent to have an IES evaluator present at your NHS trust board meetings to audio record the discussions.

Please read this information sheet carefully. If you are happy to give your consent, please sign and date the consent form and return it to the IES evaluator, Gemma Robertson-Smith, using the envelope provided. If you have any questions please contact a member of the evaluation team and they will be happy to address them.

Background to the evaluation

The Institute for Employment Studies (IES) is an independent, apolitical, international centre of research and consultancy in employment and human resource issues. IES has been commissioned by the West Midlands Strategic Health Authority to carry out an independent external evaluation of the Burdett Trust/King's Fund nurse director and Board Development Programme. The executive nurses and their trust boards taking part will be supported by The King's Fund consultants during the period April to December 2009. The bespoke programme is intended to explore, facilitate and develop models for high-quality board-level clinical engagement.

The overall aim of the evaluation study is to identify the effect of participation in the programme, especially in terms of any changes in the way clinical, quality and other patient care-related issues are perceived and talked about by board members. You will have already seen a survey request from us and those completed responses will help us to understand perceptions and views on clinical engagement.

What we intend to do next

The IES evaluators are now seeking to gain an in-depth understanding of the nature and language of care-related discussions. In order to do this, IES evaluators will audio record and transcribe two board meetings, each at three different organisations. Your trust is one of the organisations that has been selected. The first taped meeting will be as the programme commences in April/May 2009 and the second taped meeting after the programme has finished in May/June 2010. These transcriptions will then be subject to micro analysis by the evaluation team. A report detailing the findings of this and the survey findings will be produced in December 2010.

Confidentiality and data protection

This evaluation is being carried out with respect to the guidance outlined in The British Psychological Society Code of Ethics and Conduct and The Data Protection Act 1998 (IES's Data Protection Policy is available on the back of the consent form).

In order to protect your anonymity we will remove all personally identifiable information from both the audio recording and the typewritten transcripts. Nothing you say during the meeting will be attributed to you as an individual or to your NHS trust. However, we may use some completely anonymised quotes when we report our research findings.

Any data collected from evaluation participants will remain confidential to the IES evaluators and will not be seen by anyone at your organisation, SHA, or The King's Fund. Recordings and transcripts will be transported and stored securely in accordance with Data Protection requirements and will be accessed only by the IES evaluation team. At the end of the project all transcripts and recordings will be destroyed.

The evaluation team

If you have any questions about your involvement in the evaluation research please contact: your nurse director colleague <<< >>> on tel: <<<>>>; Dr Alison Carter, IES Principal Research Fellow, email: alison.carter@ employment-studies.co.uk; tel: 01273 873673; or Gemma Robertson-Smith, IES Research Officer, email: gemma.robertson-smith@employment-studies.co.uk; tel: 01273 877400

Evaluation Participant Consent Form

By signing this form you are agreeing to be audio recorded as a participant in your trust board discussions.

I understand that participation by my trust in the evaluation research will involve me being audio recorded during two board meetings. I have read and understood the information contained in the information sheet and have had the chance to ask any questions about the project and have received satisfactory responses.

I consent to be audio recorded by an IES evaluator.

Signed:

.....

Print Name:

.....

Trust:

.....

Date:

.....

Please return the completed form using the envelope provided or send to the following address:

Gemma Robertson-Smith, Institute for Employment Studies, FREEPOST BR 1665, Falmer, BRIGHTON, BN1 9BR.

IES Data Protection Policy

IES is registered under the Data Protection Act (Z5749240: certificate) for a number of purposes relating to its work where 'personal data' is held and processed.

IES ensures that when any data about individuals are sought or released to us, we will:

- hold data confidentially and securely until the end of the project, after which time it will be destroyed
- maintain our IT security policy which encompasses internal IT procedures, anti-virus controls and Internet security that ensures a secure computing and network environment
- not process sensitive personal data without explicit consent
- not use the data for any purpose other than that specified
- not disclose the individual data to a third party
- not use the individual data to support decisions or measures relating to that individual
- not publish data which allow individuals to be identified without the subject's explicit informed consent.

The definition of 'personal data' is:

> *'Data relating to a living individual (the data subject) who can be identified either from that data, or from any other information or document which is in (or is likely to come into) the possession of the data controller.'*

In short, personal data means any data (from whatever source) which relate to a named or readily identifiable individual, including any expression of opinion and any indication of the intentions of the data controller (or any other person) in respect of that individual whether contained in (or appended to) a letter, memorandum, report, certificate or other document, or held in a paper-based file, on computer, or by any other automated or non-automated means.

From Financial to Clinical? Perceptions and Conversations in NHS Boardrooms

Dr A Carter, Dr M Sigala, G Robertson-Smith, S Hayday

Board effectiveness is a hot topic and particularly scalding in two sectors. Firstly in financial services following the failure of bank boards to change the culture of large bonus payments; and secondly in the NHS where widespread criticism has been levelled at trust boards in the wake of several 'scandals' due to failure of clinical care quality. This criticism has been particularly felt in the NHS in the West Midlands which has been the focus of the Stafford Hospital Inquiry. A Burdett Trust board development programme to seek improvements in patient quality, safety and experience was run within the West Midlands during 2009-10. This report presents the findings of the IES programme evaluation study and in doing so sheds light on issues of wider interest to CEOs, chairs and board development specialist in all sectors about the engagement, governance and leadership of their boards.

Institute for Employment Studies
Sovereign House
Church Street
Brighton BN1 1UJ
Tel: +44 (0) 1273 763400
Fax: +44 (0) 1273 763401

www.employment-studies.co.uk

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