An exploratory study of the clinical content of NHS trust board meetings, in an attempt to identify good practice

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Contents

1

Executive summary

Background

Health care is undergoing radical change. Patient choice, life-style disease patterns, technical advances, foundation trusts, payment by results, PCT commissioning and regulation are key factors affecting the focus and 'business' of patient care. Reputation, customer care, marketing, risk management and innovations in the quality of patient care should have equal priority with financial acumen at board level as increasingly they become linked. However, there is a common perception that trust boards have focused their attention on meeting financial targets and reviewing performance indicators associated with star ratings as opposed to reviewing the quality or "the business of the business".

What we did

This exploratory study, commissioned by The Burdett Trust for Nursing and conducted by the University of Plymouth, studied the clinical content of NHS Trust meetings in an attempt to identify good practice. We examined publicly available board meeting minutes for a random sample of 60 Trusts. We identified trusts with higher and lower levels of clinical content and examined the minutes of a sub-sample over one year to check consistency. Minutes for two trusts with high clinical content were reviewed in more detail to identify possible factors leading to greater focus on clinical matters. Based on these reviews a checklist approach was used to review factors in low scoring trusts.

What we found

Overall 14% of items in meetings were rated as clinical but varied between 7% and 22% over the year for different trusts. Trusts with higher levels of clinical issues discussed seemed to have a chief executive officer who ensured that clinical issues were closely linked to all trust developments including finance and information technology. For example, in one board each service director gave a brief report on how their area linked both to cost savings and service development. This resulted in the Performance Management Reports being focused on actions related to clinical issues in addition to cost pressures. For example Outpatient waiting times for Children and Adolescence Mental Health Services, control of infection, patient safety incidents and the Mental Health Commissioner's report were considered in terms of value for money and quality rather than 'cost alone'.

In trusts with higher levels of clinical content, non-executive directors seemed to question and interrogate trust board executives in an open and transparent manner. For example, in one acute trust when non-executive board members asked for further information on Clinical Governance and Service improvements the chief nurse produced appropriate information at subsequent meetings. In a Primary Care Trust the chief executive and chairman appeared to have structured their working relationship in such a way that non-executives would participate in subcommittees Focusing on particular strands for integrated service and improvement plans around the Health Care Commissioner's standards.

These developments went beyond the immediate trust and included inviting local strategic partnership groups to be involved with whole borough decisions regarding directions for all services in the public, private and voluntary sector.

Comparison between trusts with higher and lower levels of clinical content suggested that more clinical staff present at board meetings, less use of acronyms in reporting the minutes, more evidence of liaison with social services, questions from the public being sometimes accepted, and infection control issues being presented, were indicators of a greater clinical focus.

Does this approach add anything to our knowledge of how NHS trusts work?

Assuming that the difference in trust meetings between the lower and higher end of 'clinical content' represents a real difference could 'better practice' in trust meetings simply be achieved by following a few simple practices or do different trusts have a different 'culture' that can not be so easily changed? Organisational culture is a complex phenomenon and various instruments that have been developed have used up to 135 items to describe it. Most also examine employee perceptions and opinions about their working environment. Our small study has looked at one aspect of NHS trusts – the board meeting. However, this may provide some useful insight into how the trust works and further research comparing this simple approach with more comprehensive assessment of organisational culture may be worthwhile.

Although a very crude method of identifying trusts that had more clinical focus, counting the number of items in Board minutes and comparing the minutes against a simple checklist, seems to have some validity. Further work is required but some 'good practices' are emerging that might be considered by all trust boards. Individuals appointed as both executive and non executive members should be given adequate preparation to ensure they are prepared to measure the performance against a range of clinical and financial benchmarks. This would ensure that the 'best practice' is further adopted in boards across a range of health care services and that new board members structure their activity to ensure that the 'business of care' is given equal importance in terms of review as that of financial performance indicators.

2

Academic summary

Objective

To explore the amount of discussion on clinical services in trust board meetings, aiming to identify trusts with higher and lower levels of clinical content, and characteristics and processes that might be considered good practice.

Methods

We reviewed one set of publicly available board meeting minutes for 60 randomly chosen trusts. Six sets of minutes over one year for each of 12 trusts with high, and 12 trusts with low, clinical content were reviewed to check consistency. Minutes for two trusts with high clinical content were reviewed qualitatively and possible factors leading to greater focus on clinical matters extracted. A checklist approach was used to review these factors in low scoring trusts. A purposive sample of three trusts thought likely to have good practice was also reviewed.

Results

Fourteen percent of items in meetings were clinical. Although, as would be expected each trust had variation over the year, when six sets of minutes were considered, high and low scoring trusts remained different in the proportion of items that were clinical. Trusts with higher levels of clinical issues discussed seemed to have a chief executive officer who ensured that clinical issues were closely linked to all trust developments including finance and information technology, and non-executive directors who were able to question and interrogate trust board executives in an open and transparent manner. Comparison between high and low scoring Trusts suggested that in high scoring trusts there was more clinical staff present at board meetings, less use of acronyms in reporting the minutes, more evidence of liaison with social services, questions from the public were sometimes accepted, and infection control issues were presented.

Conclusions

Although a very crude method of identifying trusts that had more clinical focus, counting the number of items in board minutes seems to have some validity. Further work is required but some ‘good practices’ are emerging that might be considered by all trust boards.

3

Introduction

There are five different types of trusts within the NHS. Acute trusts manage most hospitals ensuring the quality of care, efficient use of funds and developing strategies to improve services. The Ambulance trusts provide emergency access to health care and in many areas are also responsible for providing transport for patients to get to hospital appointments. Care trusts work both in social and health care offering a range of services including learning disability, mental health and primary care services. Mental Health trusts have responsibility to provide health and social care for people with mental disabilities. Primary Care trusts (PCTs) providing services to local communities, are at the centre of the NHS strategy receiving 75 percent of the NHS budget. Overall there are just under 600 NHS trusts in England, of which half are PCTs, 30% are Acute trusts and one in eight is a mental health trust [1].

Health care is undergoing radical change. Patient choice, lifestyle disease patterns, technical advances, Foundation trusts, payment by results, PCT commissioning and regulation are key factors affecting the focus and 'business' of patient care. Reputation, customer care, marketing, risk management and innovations in the quality of patient care should have equal priority with financial acumen at boards as increasingly they become linked [2].

Recently, poor standards of care and caring have had a high profile in the media. This is worrying for patients, distressing for staff and has the potential to damage the reputation and business of a health provider. The causes are multifactorial and are as much to do with organisational as professional issues [3]. There is a common perception that trust boards have focused their attention on meeting financial targets and reviewing performance indicators associated with star ratings opposed to reviewing the quality or "the business of the business".

In 2001, the UK Government started using star ratings with NHS trusts. Criteria to judge performance fell into five areas: key Government targets; performance indicators with a clinical focus; performance indicators with a patient focus; performance indicators with a capacity and capability focus; CHI reviews. The scores from these areas were combined in a complex six-step process. Some managers suggested that a number of trusts had played games with the statistics to try to improve their ratings [4]. Some managers reported them as useful but they were also reported to have a number of dysfunctional consequences including distortion of priorities, erosion of public trust, and reduced morale [4]. The way the ratings are calculated has been criticised (e.g. [5]).

This small study aims to look at just one part of a trust's performance, the way the board meetings are run. It was not clear if some trusts were 'better' than others but we thought that it was possible that some areas of 'good practice' could be identified by comparing trusts. Our aim though is to identify good practice and not to suggest that some trusts are either underperforming or have poor practice.

All trusts are required to make the minutes of the board meetings available to the public [6]. We have used these publicly available documents to explore the variation in the amount of time spent on clinical matters. Our concern was whether NHS trusts are able to spend appropriate amounts of time on their strategy and operation of clinical services or whether other matters such as finance dominate trust meetings. A recent report from the Health Service Commission and Commission for Social Care Inspection indicates that they review minutes of trust boards to identify the extent to which trusts being reviewed deal with clinical investigations and problems (Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS trust). By identifying trusts with higher and lower levels of clinical content we aimed to identify characteristics and processes of trusts that might be considered good practice.

4

Methods

This project is based on analysis of publicly available materials and so did not require ethical permission.

Sampling frame and random sample

We identified a list of trusts on the Internet [1]. We excluded ambulance trusts from this study. A random sample of 20 trusts was taken from each of Acute, Primary Care, and Mental Health (Table 1). We had intended to sample all nine care trusts, however, after sampling we noted that this Internet list 'double counted' so that by chance, two of the care trusts were included within our mental health trust sample. Three care trusts did not have minutes available on the Internet and for one, their website did not work when accessed (June 2006). We therefore did not sample care trusts. Seventeen Primary Care trusts (including 4 in our sample) were also listed as mental health trusts and one mental health trust was also listed as an Acute trust.

Trust type	Number	Sample
Acute trusts	174	20
Ambulance trusts	31	0
Care trusts	9	0
Mental Health trusts	82	20
Primary Care trusts	302	20
Total	598	60

Table 1. Sampling frame and stratified random sample

Purposive sample

From knowledge of their activities, three trusts thought likely through verbal report including national presentations to have 'good practice' were also reviewed in parallel with the main review of the random sample. These three trusts (referred to as A, B, C), had their sets of minutes reviewed for the quantitative measure of clinical content and the two higher scoring trusts had their minutes reviewed qualitatively.

Phase 1: Assessment of last set of minutes

The last set of minutes for each of the 60 trusts in the random sample was downloaded from the Internet and reviewed, classifying all identifiable distinct items in the minutes as NHS Agenda, Organisational, Financial, Clinical, Staffing, General, Positive feedback, or Complaints. Table 2 gives examples of each of these eight groups. The scoring framework was agreed by the team, which included professors of nursing and health informatics. Minutes were then categorised by a research assistant. Although no formal repeatability study was carried out, a subset of minutes was reviewed by a clinical expert with complete agreement on classification.

NHS Agenda	…Dr [name] also pointed out that the new white paper on care outside hospital would also have implications for the workforce…*
Organisational	Communication and engagement between the PCTs and service providers would be an important issue in ensuring the service realised benefits for local communities…*
Financial	That initial shadow phase will require minimal PCT funding of £200k prorate to PCT capitation across the 14 PCTs, as a contribution to the overall start-up costs for the service.*
Clinical	The main variations against the key targets concerned the breach of the nine month inpatient wait at X […] and access to a GP within 48-hours which had fallen to 91% in January*
Staffing	…A training programme for managers in staff appraisal was being introduced and a new appraisal reporting system was being developed.*
General	The minutes of the meeting held on the 12th May 2005 were approved as a true and accurate record.*
Positive feedback	The outcome of the Patient Survey 2005 was generally positive from the PCT point-of-view…*
Complaints	…also contained information about two patient complaints one of which had been the subject of a report by the Parliamentary and Health Services Ombudsman…**

Table 2. Examples of extracts from the minutes of trust meetings .*These have been shortened to avoid the Table being too large. (trust I)*

Phase 2: Assessment of six sets of minutes over one year

The trusts were ranked according to the percentage of items which were clinical. For each of the Acute, Primary Care, and Mental Health trusts, four trusts were identified as having a low number of clinical items and four as a high number. The last set of minutes plus five others over the last year (so that there was representation for all seasons) for each of this sub-sample of 24 were reviewed and similarly classified. We were unable to choose the four lowest and four highest in every case as six trusts did not have six sets of minutes available; the 24 trusts chosen are shown in Table 3. The trusts were from a wide geographical spread, however, the highest scoring trust in each trust type was located in the London area.

Trust ranking	Acute	Primary Care	Mental Health
Low clinical	3,4,7,8	2,3,4,5	2,3,4,5
	(D, E, F, G)	(H, I, J, K)	(L, M, N, O)
High clinical	17,18,19,20	16,17,19,20	16,17,19,20
	(P,Q,R,S*)	(T, U*, V, W)	(X*, Y, Z, ZZ)

Table 3. Ranking of the 24 trusts chosen for analysis of six sets of minutes (based on last set of minutes only).

Ranking trust chosen where 1 is trust with lowest percentage of clinical content and 20 is trust with highest percentage.
*Six sets of minutes examined qualitatively (Phase 3) for these three trusts.

Phase 3: Qualitative assessment of six sets of minutes for trusts with high clinical content

In an attempt to identify potential reasons for greater clinical focus, six sets of minutes over the last year were examined qualitatively for the highest scoring trust (based on six sets of minutes over the year) within the 'high clinical' category from each of Acute, Mental Health and Primary Care. This review was by a nurse researcher with expertise in clinical issues across a range of Health Care Services.

Phase 4: Influence of those attending trust meetings

The qualitative assessment in Phase 3 suggested that the roles (i.e. the job titles) of the people present at meetings may be influential in whether there were many clinical items discussed. We, therefore, classified the job titles of all present for the last set of minutes for the 60 trusts to see if this was a predictor of clinical content.

Phase 5: Checklist assessment of last set of minutes for trusts with low clinical content

Qualitative assessment of trusts with higher clinical content suggested a number of practices that might be thought of as 'good practice' and that might be responsible for the higher level of clinical content. The minutes of three trusts with the lowest clinical content over one year were reviewed together with the three highest scoring trusts whose minutes were qualitatively analysed using a checklist based on these practices.

5

Results

Phases 1 and 2

How many items were there in the minutes?

The number of items classified in each of the 60 sets of minutes ranged from 23 to 143. Averaged over the 60 trusts, the minutes recorded that more general, organisational and financial rather than clinical items were discussed (Table 4).

Item type	Minimum	Maximum	Median	Mean (SD) %
NHS agenda	0	5	0	0.7 (1.4)
Organisational	7	44	17.5	27.6 (8.4)
Financial	1	46	12	19.2 (9.1)
Clinical	1	27	10	14.3 (7.0)
Staff	0	22	5	8.7 (4.3)
General	4	48	19	28.5 (10.3)
Positive comments	0	2	0	0.4 (0.9)
Complaints	0	5	0	0.7 (1.3)
ALL	23	143	69	100

Table 4. Number of items in the last set of trust minutes for 60 randomly chosen trusts

Is the percentage of clinical content consistent?

14.3% (SD 7.0) of items in the 60 sets of minutes were clinical. The estimate using the 24 trusts and their last six sets of minutes was very similar (13.3%). However, there was a considerable range in the discussion of clinical items between meetings from 2-30% in the last set of minutes. There was consistency in which trusts had ‘low’ and ‘high’ clinical content. Figure 1 shows the mean clinical content of six sets of minutes compared to the clinical content of one set only for those 24 trusts which were sub-sampled. As would be expected there was less variation in clinical content when the mean of six sets were considered and there is some indication of ‘regression to the mean’. Nevertheless those which were high and low scorers using one set of minutes tended to remain as high and low scorers.

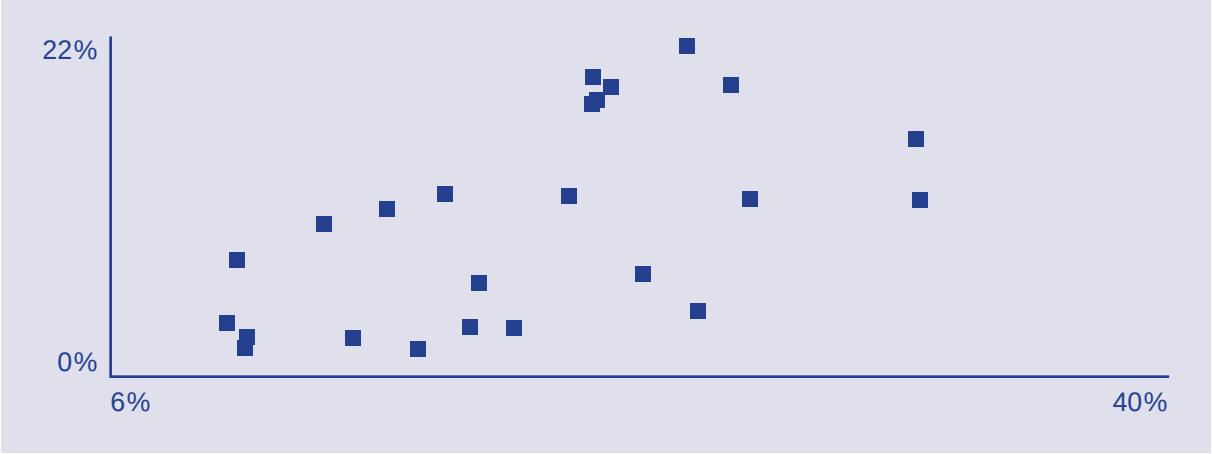

Figure 1. Percentage of 'clinical' items in last set of minutes (x) compared to the mean of six sets of minutes over one year for 24 trusts (y).

Table 5 shows that when considering the 12 trusts that were sub-sampled as 'low' versus those sub-sampled as 'high', again there appears some consistency, with some regression to the mean.

	Last set of minutes for 60 trusts	Mean of six sets of minutes over one year
Sub-sample low	9.2% (3.9)	9.5% (2.3)
Sub-sample high	21.1% (5.3)	17.1% (3.2)

Table 5. Comparison of the percentage (standard deviation) of items rated as clinical using the last set of minutes and using six sets of minutes over one year for 24 trusts

Other items discussed

Table 6 shows the percentage of topics discussed from the mean of six sets of minutes. As would be expected the percentage of clinical items is greater in those in the 'high-clinical' sub-sample but no other items were significantly less. This suggests that higher clinical content was not at the 'expense' of any one other item but in slightly lower percentage of all other content.

Type of content	Sub-sample 'low clinical'	Sub-sample 'high clinical'	Probability from t-test
Clinical	9.5	17.1	<0.001
NHS Agenda	1.0	0.8	0.64
Organisational	30.4	25.9	0.07
Financial	18.0	15.1	0.23
Staff	10.8	10.0	0.51
General	29.2	29.6	0.90
Positive comments	0.5	0.2	0.57
Complaints	0.6	1.1	0.10

Table 6. Comparison of percentage of items in six sets of minutes over one year for 24 trusts

Purposive sample

The percentage of clinical items for the purposive sample (last set of minutes only) was 11.3 (Trust A), 15.9 (Trust C), and 20.0% (Trust B) which would have ranked them 25th, 36th and 47th out of the 60 trusts. So although none were in the bottom quartile of clinical content neither were they clearly 'top' of the rankings, (e.g. none were in the top decile). Qualitative analysis was undertaken on the latest set of minutes for the two trusts with the highest clinical score.

Phase 3: Qualitative review

Three trusts with the 'highest clinical content' over one year

1. Mental Health (Trust X)

This mental health trust's minutes illustrated an integrated approach to review of service delivery within the trust. The chief executive's report regularly included a section 'Service Review Against Targets'. The nurse director's report focused on Clinical Governance issues including NICE Schizophrenia Guidance, Suicide Prevention Strategy, User Survey, Complaints, Service Improvement, Infection Control and the At Risk Register.

Six sets of minutes for each trust were reviewed by a clinical expert to gain a deeper understanding of the trust board's reported discussions over a one year period. A qualitative approach based on case study analysis was utilised [7]. This approach is designed to promote validity in qualitative research interpreting data through cross checking for convergence and divergence in data by identifying emerging themes and considering the meaning of data through analysis by experts in the field.

The chief executive's report and the nurse director's report were closely interlinked as was the medical director's report. Each service director gave a brief report on how their area linked both to cost savings and service development. This resulted in the Performance Management reports being focused on actions related to clinical issues in addition to cost pressures. For example, outpatient waiting times for children and adolescence mental health services, control of infection, patient safety incidents and the Mental Health commissioner's report were considered in terms of value for money and quality rather than 'cost alone'. Perhaps particularly importantly non-executive board members asked for further information on Clinical Governance and Service improvements. The chief nurse agreed to produce further information at subsequent meetings and this was achieved. The medical director and nursing director focused their strategies on ensuring that evidence based care was encouraged within the trust and that NICE Guidelines were reviewed and implemented as appropriate. For example a new policy for prevention and therapeutic management of aggression was discussed and supported at the board based on this approach.

The finance director had ensured that each service director had been asked to provide him with a brief report on how they planned to make necessary cost savings in the future. The focus, therefore, of the finance director's potential efficiency savings was to ensure that consideration was given to potential service effect where savings were to be made. An exemplar of this approach involving inter-professional team work across the full range of health care professionals and Social Services had resulted in 'Crises Resolution and Home Treatment Teams having a positive impact resulting in the closure of 42 in-patient beds'.

The chief executive and board were clearly interested in reviewing service development and linking this to cost effective care. A key issue in this set of board minutes was that the interrogation that was undertaken by Non-executives at the trust board of the executive members tended to be client focused. Although it is difficult to draw firm inference from these minutes, the trust minutes gave the impression that the entire board were committed to developing service improvement while ensuring cost effective measures were employed to achieve these aims. The board were given leadership from the chief executive to review changes in the service in relation to likely effects for the client population.

In summary, the clinical governance focus within this trust included patient safety, infection control, aggression management and complaint reports; to identify how to reduce problems associated with complaints. Equal time for reporting seemed to be given to the nurse and medical directors and although on at least two occasions the finance report was extremely long, the relationship of this report to clinical review resulted in clinical issues being discussed under the three main directors' reports (finance, nurse and medicine).

2. Primary Care trust (Trust U)

The chief executive's report for this inner-city London PCT focused on some of the following issues which were followed through over a period of three to four board meetings: 'Commissioning of Patient-Led NHS', 'Focusing on Choose and Book' and the 'Health Commissioner's Core Standards'. This agenda was linked to the Professional Executive Committee (PEC) report for the board. The PEC report focused on quality and outcomes framework including a clinical assessment project. It was interesting to note that the PEC had discussed the PCT Estates Strategy from a clinical perspective and fed this in to the relevant director in relation to the long term estates' strategy. Therefore, there appeared to be a link between the PCT estates' strategy and clinicians' involvement with regard to the quality and framework necessary to provide optimum services.

At one meeting the medical director reported on the National Service Framework for Older People and a nurse director outlined an integrated service improvement plan linking social care with primary health care delivery. The board non-executive members were reported to have asked for further information on community initiatives in Mental Health Care for Older People and the PEC report presented minimum standards above contract level which would be set and monitored in relation to this issue.

There were three PEC key objectives regularly discussed at board meetings with regard to 'Clinical Leadership', 'Communications', and 'Lifelong Illness'. The PEC and nurse executive report gave the impression that the nurse executive was taking the lead on education and training of clinical leaders in order for PEC objectives to be achieved. Review of the minutes suggested that both executive and non-executive directors were working together as a team to achieve mutually identified strategic objectives. For example when the chief executive's report focused on reviewing the Health Care Commissioner's Core Standards, the non-executive directors were reported as having 'welcomed their involvement in reviewing trust developments against the Health Care Commissioner's Core Standards (N=38) regularly at board meetings.'

The chief executive and chairman appeared to have structured their working relationship in such a way that Non-executives would participate in subcommittees Focusing on particular strands for integrated service and improvement plans around the Health Care Commissioner's standards. These developments went beyond the immediate trust and included inviting local strategic partnership groups to be involved with whole Borough decisions regarding directions for all services in the public, private and voluntary sector. The trust had a focus to reduce health inequality in the Borough and enhance practice.

For example the medical director explained that the incident reporting policy and follow-up procedure had been amended. He assured the board that 'Forthcoming changes were designed to encourage the reporting of clinical incidence and 'near misses' in order to improve clinical practice'. 'The policy supported a 'fair blame' approach. The emphasis was on learning from incidence across the organisation and reviewing the systems in place rather than apportioning blame to individuals'.

The chief executive officer reported links to Children's trusts, the response to Health Care Commissioner's consultation for assessment for improvement and it was agreed that the PEC would take the lead role in providing the board with 'A clinical/practitioner's viewpoint, in areas such as NICE Guidelines and improving achievements against targets'.

The minutes suggested that the chief executive officer and all board members were committed to supporting the development of Foundation trusts while ensuring that their focus on reviewing clinical quality delivery was enhanced. The trust board when evaluating services did so with the aim of reviewing 'How best to meet the needs of existing and potential service users and also provide best value for money'. It was this collegiate approach between executive members, led presumably by the chief executive officer that appears to have ensured that the focus of work continued to ensure that care was regularly reviewed at trust board level.

3. Acute trust (Trust S)

The minutes from the Acute trust were the only set examined in the 'high' category where questions were accepted by the board from the public at their meetings. This may have contributed to ensuring that the trust board focused on clinical outcomes and clinical issues. In this trust, the chief executive officer's report included issues relating to cancer waiting times and the extent to which quality of care was being maintained in relation to the trust's improvement in financial control. The tone set by the CEO's reports was reflected in other executive directors' integrated approach to reporting on specific items.

The CEO reported that the trust had received an award for being one of the top 40 hospitals for clinical performance, indicating that the extent to which clinical issues are discussed at the board may be linked to the quality of care. The CEO and other board members were reported as having thanked staff in the achievement of this award, recognising 'The achievements of clinicians, supported by management, in gaining this award'. It is interesting to note the tone of the CEO's leadership in the way he recognised the achievement of clinicians supported by management. This gives the impression that the management team of this trust believe it is their duty to set the strategy to provide the right environment for clinicians to achieve, therefore, setting a collegiate approach to the delivery of care. The CEO also reportedly recognised the need for continuous review and improvement and, therefore, despite achievement of this award was not expecting that the award was an end in itself.

During the period reviewed through the minutes in this Acute trust, there were two nurse directors. One nurse director reported several examples of innovative practice and care including the need to review the efficacy of certain interventions, for example the use of hydrotherapy for patients who had had total knee replacement. A non-executive director questioned the nurse director in relation to protected meal times. The nurse executive director subsequently responded to this question at a follow-up meeting and was able to assure the non-executive director that in addition to protected meal times the trust was actually evaluating the extent to which this was enhancing the nutritional status of in-patients. Two other non-executive directors asked questions of the nurse director. There appeared to be an honest and open exchange between the Non-executives and the executives in this trust.

The finance director, when examining potential cost savings, explained that all executive directors had been asked to examine how changes in terms of value for money might affect patient choice before final decisions were made in relation to the strategy.

The Health Informatics director presented a report on the Health Informatics Strategy. There were five strands to this work, including 'care pathways' and the development of 'clinical systems' rather than 'administrative systems'. The chairman described the system as being on 'The critical path for improved clinical outcomes and that it would ultimately raise the quality of patient service'. The chief executive echoed this sentiment and described how 'The Health Informatics Strategy would drive patient improvement'.

When the corporate affairs director reviewed complaints this was done by examining for emerging themes which included concern with regard to clinical treatment, communication and staff attitudes. These issues were linked back to the trust's workforce development review to ensure that training on appropriate areas was encompassed in the staff development plan.

The members of this board appeared to have developed significant trust between the executive and non-executive directors which to some extent was illustrated through their questioning of each other and the acceptance of questions from the public. The questions from the public reported during the period reviewed included:-

- Asking the nurse director how many visitors were allowed at a bed at a particular time.
- Asking the chief executive what the effects of becoming a Foundation trust may be on clinical care.

The corporate affairs director responded by discussing at some length the patient care and public involvement strategy for the future.

4. Summary of three trusts with 'high clinical' category

In summary, of the three trusts examined in depth within the 'high' category reported review of clinical issues at board level, there appear to be two key themes emerging:

1 That the chief executive officer takes a leadership role in ensuring that clinical issues are closely linked to all trust developments including finance and information technology.

2 That non-executive director's question trust board executives in an open and transparent manner, with both parties aiming to enhance the care and treatment provision provided.

These trusts all seem to have commitment to ensuring staff were adequately prepared to give high quality care and at least two regularly review NICE Guidance to ensure that this is met within the trust guidelines for practice.

Characteristics of the minutes identified as possible indicators of higher clinical content included:

- The presence of Clinical directors at a proportion of board meetings
- The presence of additional clinical staff
- A more open attitude towards the public including acceptance of questions from the public and less use of jargon and acronyms
- Evidence of liaison with Social Services
- Infection control issues being discussed.

Two trusts purposively sampled

Prior to commencing this project, two trusts had been recommended as areas of good practice through personal communications in terms of examining clinical issues at board level. In particular, it had been argued that the boards were structured to ensure clinical issues were examined at every board meeting. Therefore, minutes from the last board meeting of each of two trusts were also examined to establish whether there were similarities with the randomised sample and/or whether further good practice could be identified.

In the mental health trust, (Trust C), the format of trust board minutes was similar to the mental health trust identified from the randomised group (above). The key issues included the trust nurse director's and medical director's reports and the chief executive's in leading the team's focus on ensuring Mental Health Services were leading edge. The CEO of this MHT reported having had a robust exchange with the PCT requesting why Mental Health Services should be affected financially when underlying cost pressures related to Acute Health Care Sector. It appeared from this trust that all board members had a real commitment to Mental Health Care led by the chief executive.

The Acute trust, (Trust B), reviewed adopted a very structured approach to the reporting of their minutes which may be useful for other trusts to consider. These were as follows:

1 A presentation by a 'team of the month'. This seemed to enable both executive and non-executive directors to understand the core issues at service delivery.

2 The board was structured in such a way that each project agreed by the board had an executive director sponsor who was then expected to report. This appeared to be particularly pertinent for integrated service improvement programmes. Teams involved in programme change were regularly invited to the trust board and once an agreement had been given to move forward on a project, the teams were only asked to return if they were experiencing problems or issues in achieving the project that had been agreed by the board. Presumably, this gave the project team the knowledge that they had the full support of the board, but also delegated autonomy to go and achieve outcomes unless problems were experienced.

3 At this board, performance monitoring was regularly reviewed and the director of nursing and operations was the sponsor for performance monitoring. She gave regular reports in relation to changes in care including substitution of consultant appointments in Orthopaedic activity by those from another profession. She emphasised the need to ensure that clinical outcomes remained at least as good as in traditional terms and, therefore, the need to regularly review patient outcome associated with this development.

4 Monthly reports on patient and public involvement in the trust were sponsored by the medical director. The aim of this report was to review the extent to which excellent patient experience and excellent governance linked.

5 Following some discussion, it was agreed that the chief executive officer would regularly report on service improvements within his report to the board.

This trust had a structured approach to reporting clinical issues through each executive director to the trust board.

While financial challenge was clearly being experienced, this had been accomplished with considerable effort and the lessons learned were being translated into new systems and processes to ensure that the performance was sustainable.

The systematic approach adopted to review clinical issues in Acute trust (B) was not identified as such a consistent factor in other 'high' category trusts selected randomly.#

Phase 4. Attendees at trust meetings

Fourteen (23%) out of 60 trusts did not record the job titles of those present. The director of nursing was present in 31/46, medical director in 25/46, and some other 'clinical person' in 27/46. The latter included directors of Mental Health Services, Community Health Services, and Public Health, PEC nurse Consultant, and nurse Lead. For one meeting there were no clinical people present, for eight only one, and for 37 two or more clinical people present. There was no obvious difference in the number of clinical items discussed whether or not there were clinical people present (or whether people's job titles were noted in the minutes) when reviewing the last set of minutes for 60 trusts. We did not examine differences by presence or otherwise of lay members. In retrospect, the presence of lay members may influence time spent on the 'business of the business' as lay members may feel more comfortable with this aspect. This deserves further investigation.

Phase 5. Review of meetings with higher vs. lower levels of clinical content

All six sets of minutes were reviewed for the three trusts qualitatively reviewed and three randomly selected trusts with less clinical content. We, therefore, considered 36 sets of minutes and present here the relationship between clinical content for each set of minutes against key indicators.

Clinical staff present: There was some relationship between the number of clinical staff present and clinical content. Meetings with only one or with no clinical person had 8.3%, with two clinical staff 12.9%, and with more than two clinical staff 16.9% of clinical items ($F=3.3$; $p=0.05$ in Analysis of Variance). It could be of course that meetings with a planned higher clinical content invited or attracted more clinical staff.

Use of acronyms without explanation: 12 out of 36 minutes used acronyms without explanation. These meetings were likely to have lower clinical content (7.6% Vs 16.1%; $t=-4.2$; $p<0.001$).

Other clinical staff (non-board members) present: 15 out of 36 meetings had other clinical staff present but there was no relationship with clinical content of the minutes.

Evidence of liaison with social services: Nine out of 36 sets of minutes recorded evidence of liaison with social services and those meetings had a higher clinical content (20.0% Vs 11.7%; $t=3.1$; $p=0.004$).

Questions from the public accepted: Half the meetings accepted questions from the public and these showed some signs of higher clinical content but the difference did not quite reach statistical significance (16.2% Vs 11.4%; $t=2.0$; $p=0.06$).

Infection control issues presented: In 15 out of 36 meetings infection control issues were presented. These meetings had higher clinical content than other meetings (18.4 Vs 10.5%; $t=3.5$, $p=0.001$).

6

Discussion

General approach

This was an exploratory study that aimed to identify characteristics and processes of trusts that might be considered ‘good practice’ in having a greater focus on clinical matters. We have approached this by using published trust minutes to identify those trusts with higher and lower levels of clinical content, qualitatively using the minutes to see if we can identify good practice, and carrying out some preliminary testing of whether some characteristics are indicators of a greater focus on clinical aspects of trust activities.

Validity of methods

Can we classify a trust as being more or less clinically focused simply by looking at the clinical content of the minutes of the last meeting? We demonstrated that if we looked at six sets of minutes over one year and not just the last set that although, as would be expected there is less variation in clinical content and trusts with high or low clinical content regress towards the mean, one set of minutes was quite predictive of minutes over the year. Thus although there is likely to be variation over the year as, for example, various clinical director reports may be considered in a particular meeting, some trusts do regularly seem to have a considerably greater clinical focus than others.

The qualitative, ‘reading’ of the minutes looking for examples of good practice, was carried out by a nurse researcher with considerable experience of management. She had no connection with the randomly chosen trusts or the process of selection of trusts likely to have ‘good practice.’ Two senior nurses associated with the Burdett Trust were also consulted at preliminary draft stage. They considered the following data to “make sense” in terms of clearly relating to clinical issues. Therefore, although not reported the themes are considered valid.

Is variation in clinical content organisationally significant?

Clearly, if you rank order according to any variable and then compare a sample at the top and bottom of the distribution you are likely to see a statistically significant difference. The relevant question is whether trusts that spend 17% of their time discussing clinical content are ‘better’ in some way than those who only spend 10% of their time. This may not be considered a big difference in statistical terms, but may well be significant in indicating the commitment of the board to set strategies to enhance, promote and monitor clinical activity and quality within the ‘business’.

Therefore, there may be practices that trusts at the higher end of clinical content have that could be adopted by those at the lower end. On the other hand a review of the international literature on methods of reporting the quality of health care concluded ‘Falsely labelling providers as ‘poor performers’ may have considerable deleterious effects and is not that rare (research suggests that up to three-quarters of providers labelled as ‘poorly performing’ may in fact be no worse than average). [8]. Over interpretation of the data from our own simple and quick study should be avoided.

How trusts with higher clinical content seem to work

Reading of information from the three trusts with ‘High Clinical Content’ suggested that these trusts had a chief executive officer who took a leadership role in ensuring that clinical issues are closely linked to all trust developments including finance and information technology. In these trusts non-executive directors questioned trust board executives in an open and transparent manner and there seemed to be a commitment to ensure staff were adequately prepared to give high quality care. The executive members for nursing and medicine were expected to brief the board on clinical issues relative to agreed targets, complaints and developments.

Indicators of good practice

Some more detailed characteristics were explored in a more quantitative way comparing low and high clinical content board meetings. All six sets of minutes were reviewed for the three trusts qualitatively reviewed and three randomly selected trusts with less clinical content. We, therefore, considered 36 sets of minutes and present here the relationship between clinical content for each set of minutes against key indicators.

The strongest indicators of clinical content (and hence with our assumption, ‘good practice’) were the openness of the meeting to public scrutiny. In 36 sets of minutes for six trusts, the use of acronyms without explanation was a strong predictor of lower clinical content. Whether or not questions were accepted from the public was also slightly associated with level of clinical content. Evidence of liaison with Social Services and whether or not infection control issues were presented were also good predictors of clinical content. Most meetings had clinical staff present and although there was some indication that this increased the clinical content of the minutes the association was not strong and could be a result of planned clinical content rather than the causation of more clinical content.

Preconceived ideas

Our purposive sample of two trusts who, a priori, were expected to have higher clinical content were only average in their clinical content count. The highest of these, Trust B had the 13th highest clinical content out of 60 trusts. The Acute trust (B) adopted a systematic approach to ensuring clinical issues were reviewed regularly at board meetings. The Mental Health trust purposively reviewed illustrated examination of a range of clinical issues at the board. However, neither trust was “better” in terms of considering clinical issues than those identified in the randomised sample as “high clinical content”. Perhaps, therefore, the two trusts investigated in the purposeful sample are better at “reputational management” than the norm. In any event, it is helpful to identify that even if the preconceived perception of these trusts being good is partly reputational on examination, both boards were evidenced to regularly review clinical issues indicating a degree of relationship between anticipated actual content and clinical reporting at board meetings.

Does this approach add anything to our knowledge of how NHS trusts work?

Assuming that the difference in trust meetings between the lower and higher end of ‘clinical content’ represents a real difference could ‘better practice’ in trust meetings simply be achieved by following a few simple practices or do different trusts have a different ‘culture’ that can not be so easily changed. Scott et al discuss the nature of organisational culture and have reviewed quantitative measures of ‘organisational culture’ in health care [9]. Organisational culture is a complex phenomena and the 13 instruments that they describe involve the collection of between 13 and 135 items and all examine employee perceptions and opinions about their working environment. Our small study has looked at one aspect of NHS trusts – the board meeting. However, this may provide some useful insight into how the trust works and further research comparing this simple approach with more comprehensive assessment of organisational culture may be worthwhile.

Preparation of new board members

It is evident that the trusts with boards that regularly included clinical issues were frequently led by chief executives and Chairmen who encouraged the discussion and review of such issues. It is recommended that individuals appointed as both executive and Non- executive members should be given adequate preparation to ensure they are prepared to measure the performance against a range of clinical and financial benchmarks. This would ensure that the ‘best practice’ is further adopted in boards across a range of health care services. Indeed this report while not wholly generalisable because of the limited sample size and methodological approaches adopted could be used to inform new board members of the importance in structuring their activity to ensure that the ‘business of care’ is given equal importance in terms of review as that of financial performance indicators.

7

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