



Making the **safety** of patients
everyone's highest **priority**

The 'How to Guide' for **Leadership for Safety**

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Thanks to the English Campaign team members and others who have contributed to the adaptation of this guide.

Intervention lead:

Cavanagh, Peter: Consultant Radiologist & SPI lead; Taunton & Somerset NHSFT, Consultant Advisor on Patient Safety; Somerset PCT, Medical Advisor; Southwest SHA

Campaign team contributors:

Clarke, Julia: Associate (Safer Care); NHS Institute for Innovation and Improvement

Fletcher, Martin: Chief Executive; National Patient Safety Agency

Jones, Kate: Head of Programme (Safer Care); NHS Institute for Innovation and Improvement

Ramsden, Stephen: Chief Executive; Luton & Dunstable NHS Foundation Trust, Campaign Director; Patient Safety First

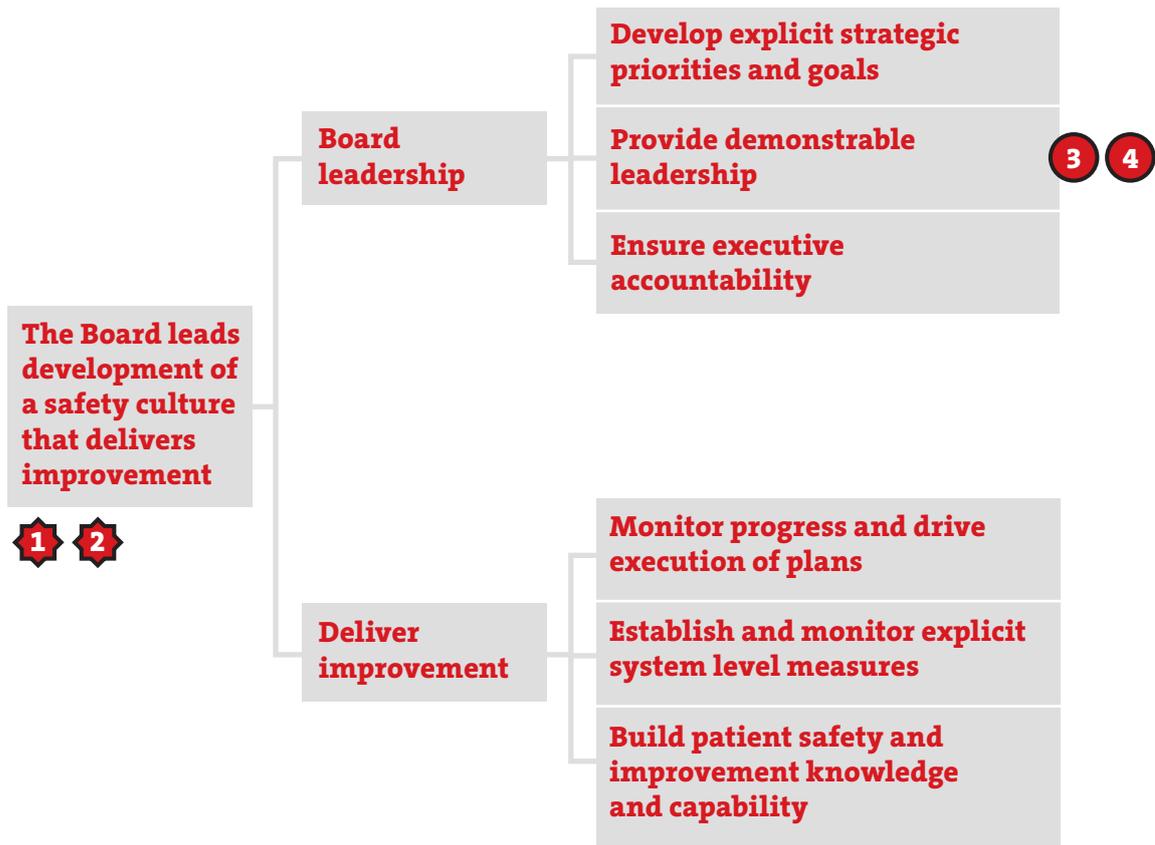
Williams, Mike: NHS Research Fellow; University of Exeter

Woodward, Suzette: Director; National Patient Safety Agency

Editor:

Clarke, Julia: Associate (Safer Care Priority Programme); NHS Institute for Innovation and Improvement

Overview of the Intervention: Leadership for Safety



- 1** Hospital standardised mortality rate (HSMR)
- 2** Adverse incident rate (obtained by use of UK Global Trigger Tool)
- 3** Number of safety walkrounds per month
- 4** Number of safety walkround actions completed per month
- Overarching Campaign measures
- Recommended Campaign measures

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General Introduction

All over the world, including in the UK, health care workers are proving that patient safety can be greatly improved and many complications or harm events that were previously considered unavoidable actually are avoidable. They are in fact, redefining what is acceptable in terms of patient safety.

The purpose of each of the Patient Safety First interventions is to provide you with a focus on which to begin or progress improvements in patient safety in your organisation. Each proposed intervention has an underpinning evidence base that identifies the need for change and how its elements can help you on a journey that will make a real impact on rates of patient harm and death.

The proposed elements, suggested changes and associated measures discussed in this document are not exhaustive; rather, a basis on which to start making a difference in the given area. It also provides a sound methodical approach that can be applied repeatedly in other improvement efforts you may wish to initiate.

The content of this guide will never be considered to be final. Regular reviews will be conducted to update it with new evidence, initiatives and key learning from organisations participating in the Patient Safety First campaign. Your suggestions for improvement and case studies are welcomed; please share your learning with your local campaign contact or contact us direct via the Patient Safety First website www.patientsafetyfirst.nhs.uk.

Leadership for Safety

The purpose of this guide is to provide Board members and senior leaders with an overview of how they can develop their role and responsibilities in leading a safety agenda in their organisation and actions they can undertake to achieve this.

Background

Outmoded views of hospital governance sometimes suggest that hospital Boards are responsible primarily for the organisation's financial health and reputation. These responsibilities are unquestionably important, but the Board's duties do not end with financial stewardship; Boards oversee mission, strategy, executive leadership, quality and safety. Boards especially guard quality of care; they are expected to fulfil an oversight role in quality assurance, and the continuous improvement of the care provided by the hospital. In the modern view, Boards bear direct responsibility for the hospital's mission to provide the best possible care and avoid harm to patients. This responsibility cannot be delegated to the clinical staff and service leads; ensuring safe and harm-free care to the patients they serve is the Board's job, at the very core of their moral responsibility.

Healthcare is a complex undertaking. Things will always go wrong in complex systems yet some organisations show greater mindfulness to the dangers that can arise than others. In other high risk industries (Aviation, Oil, Nuclear) the incidence of serious events has been reduced by several orders of magnitude through a focus on safety, communication and individual behaviours (human factors). By focusing on the contributory elements of safety, disasters in such high risk industries have become much less common. Health systems have competing priorities but increasingly there are leaders who recognise that providing a safe and reliable service is good for patients and can help to reduce the costs associated with errors. The Patient Safety First Campaign will be working with the Clinical Human Factors Group to develop a more detailed resource for NHS leaders on building a high reliability organisation.

One primary function of senior leaders in health care is to support their 'followers' in developing behaviours, skills, habits, processes, and technologies that lead reliably to dramatically improved performance. Once the vision and aims are established there are three key activities of leadership to achieve the vision:

1. **Build Will** in the form of visible, constant, unrelenting, and well-explained commitment, starting with the organisation's leaders.
2. **Ensure Access to Ideas** about the clinical best practices and support processes, and insights about how to introduce them, so that the organisation has readily available designs and concepts that are superior to the status quo.
3. **Attend Relentlessly to Execution.** Integrating improvement actions and review into the daily work of the organisation, and ensuring that better results are sustained, and spread throughout the organisation.

If any one of these three is missing, the process of change can easily stall or have far less impact on patient outcomes. Deficient will is a common culprit. Without it, senior leadership will be insufficient even where innovations and best practices are plentiful. Leaders who ignore improvement activity, or fail to adequately support it; send a strong implicit message that improving the quality of care is of secondary importance to other considerations (e.g. financial concerns), a message that can destroy energy and drive resources into activities that have far less impact on patient outcomes. The Will-Ideas-Execution approach has been incorporated into the actions suggested in this guide.

Further information on Will-Ideas-Execution can be found in:

5 Million Lives Campaign. Getting Started Kit: Governance Leadership 'Boards on Board' How-to Guide. Cambridge, MA: Institute for Healthcare Improvement; 2008. www.ihl.org/nr/rdonlyres/95eadb8f-3ad6-4e09-8734-fb7149cfd14/0/boardhowtoguide.doc.

A Leadership Checklist for Patient Safety

To ensure the Board collectively and individually provide the appropriate leadership they should seek the answers to some simple questions. The following checklist will act as a focus to those actions/interventions you will need to make in order to answer these questions and develop an appropriate action plan with clear priorities and timescales. More details of the actual intervention actions we recommend are found in the later section 'Implementing Leadership for Safety'.

What do I know about the safety of my organisation now?

- Undertake a safety culture assessment using a recognised tool
- Initiate case note review using the Global Trigger Tool and a mortality matrix tool
- Use root cause analysis (RCA) when investigating incidents with Board level feedback of significant learning points
- Integrate and review safety data from a range of sources to better understand sources of risk. For example complaints, claims, serious untoward incidents, incident reporting
- Do an in-depth case review of the experience of one patient.

Where must we do better?

- Use what you have learnt to set a goal for action which should be aspirational, inspirational and measurable
- Develop a clear set of priorities for action
- Devise a clear plan of action which includes agreement about the roles and responsibilities of Board members
- Sit down with your senior clinical staff and decide which Campaign intervention(s) you will choose to focus your energies on
- Provide clear and demonstrable support for the Campaign intervention(s) chosen and monitor progress, providing support along the way.

How do I know if we are improving safety?

- Ensure the Board receives a set of safety performance measures as part of the Board's balanced scorecard to include such measures as Hospital Standardised Mortality, incident rates, infection rates
- Continue to review safety data from a range of sources to better understand sources of risk. e.g complaints, claims, serious untoward incidents, incident reporting.

How can I show clear personal commitment to improving patient safety?

- Ensure safety is appropriately represented on all Board agendas
- Go out and see, meet your staff. Participate in the use of a tool such as safety walkrounds
- Conduct a safety diary exercise. Review your diary for personal commitment to safety.

What skills and capacity do we need to build to make this happen?

- Ensure you understand improvement methodology
- Ensure that staff have access to appropriate resources and training
- Ensure that there is focused leadership to execute the plans you put in place.

How do we know how successful we have been?

- Measure the level and stages of implementation of the Campaign intervention(s), from the planning stage to partial implementation and to full implementation.

Implementing Leadership for Safety

The Patient Safety First Campaign asks leadership of participating organisations to begin, at a minimum, by focusing on six actions to improve quality and reduce harm.

1. Develop explicit strategic priorities and goals
2. Provide demonstrable leadership
3. Ensure executive accountability
4. Establish and monitor explicit system level measures
5. Monitor progress and drive execution of plans
6. Build patient safety and improvement knowledge and capability

These were developed by adapting information from the following documents for the English Campaign context:

- *5 Million Lives Campaign, Getting Started Kit: Governance Leadership 'Boards on Board' How-to Guide.* Cambridge MA: Institute for Healthcare Improvement; 2008. (www.ihl.org)
- *National Patient Safety Agency. Leadership Safety Checklist.* 2008
- *Reinertsen J, Pugh M, Bisognano M. Seven Leadership Leverage Points for Organisation-level Improvement in Health Care. IHI Innovation Series white paper.* Cambridge, MA: Institute for Healthcare Improvement; 2005. (www.ihl.org).

Amongst these six actions are some overlapping themes but taken together they have been shown to make a major impact on the organisation's ability to lead improvement in the safety and quality of patient care.

1. Develop explicit strategic priorities and goals

Specific Aim

Organisations that develop a specific aim statement for patient safety improvement – effectively integrated into the organisation's strategy, provide clarity and direction for all staff. The aim should be aspirational and translate into measurable objectives. Examples could be:

'We will have no preventable injuries or deaths by July 2010.'

or

'One specific goal in our strategy is to achieve zero central line infections for the entire organisation, across all services by August 31, 2009.'

Where an organisation has already specified aims relating to safety it is worth reviewing them to ensure they convey the desired message and clarity. Incorporation of a spread strategy will also ensure staff are aware that these aims are not a passing project but part of an ongoing plan for safety improvement. Once agreed, if these aims and objectives are communicated, both within and outside the organisation, an explicit public commitment to measurable improvement is made.

Patient Voice at the Board

The patient voice is particularly powerful when heard directly at Board level. This can be achieved through the use of specific patient stories at Board meetings to aid understanding of the nature and sources of hazards in a complex healthcare organisation, and the impact on patients, families and staff. It is recognised that this is one of the most challenging themes and it is proposed that an incremental approach to implementing this intervention is taken. A suggested approach is outlined in *Appendix 1*.

The Institute for Healthcare Improvement (IHI) guidelines for using patient stories with Boards can be downloaded from www.ihl.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/GuidelinesforUsingPatientStorieswithBoardsofDirectors.htm.

2. Provide demonstrable leadership

When leaders commit genuine attention to improving quality and safety, so will the rest of the staff. In order to make the organisation's commitment to prioritising safety explicit, executives and senior leaders should consider the following activities:

Board Agendas

Progress towards safer care should be the first agenda item at every Board meeting and the way in which the Board is supported by the work of any sub-committees should be made explicit. This approach can be cascaded throughout the organisation so that safety becomes the first item on every agenda and in communications such as staff bulletins.

The Board should spend a significant proportion of its time on patient safety and quality issues, the Patient Safety First Campaign (as with other similar campaigns around the world) suggests Boards gradually work towards an aim of spending approximately 25% of their time addressing patient safety and quality. This shift in focus would need to be balanced with the demands placed on the Board's role in overseeing strategy; whilst the Board may be gaining greater insights into patient safety as a result of implementing elements within the intervention, they still need to concentrate on the bigger picture and avoid a volume of detail unless there is a specific issue with progress that requires their attention and support. A well planned safety scorecard can help avoid this and this is discussed further in action 4 (Establish and monitor explicit system level measures).

The Board may wish to establish a process to review agendas over a set period of time, to assess if there is sufficient time and attention being paid to quality and safety.

Safety Diary Exercise

Leaders could carry out a review of their diaries to assess how much of their time is spent directly in the pursuit of safe care within their organisations. As a result, re-alignment of activities may be considered as part of their personal development programme.

Executive Safety Walkrounds

Leaders need to interact with staff frequently, visiting their work place and asking for frank input. When all executives commit to regular visits (walkrounds) to frontline clinical and patient services, it can create a shared insight into the organisation's safety issues. Walkrounds have already been shown to be very effective in the hospital setting; the Campaign provides an opportunity to develop and test this tool which can be used in primary care and other non-hospital settings. Key themes and significant information from walkrounds are fed back to the Board. Boards should consider whether non-executive directors should participate directly in such walkrounds.

Implementing walkrounds can initially sound simplistic but significant planning and preparation is required to ensure resultant issues and concerns are recorded, actioned and tracked. A suggested approach to doing a first walkround can be found in *Appendix 2*.

Tools and supporting information are currently in development for the Campaign but the original IHI materials are available at www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/PatientSafetyLeadershipWalkRoundsDatabase.htm.

Establish an environment that is respectful, fair and just. Commit to establish and maintain an environment that is respectful, fair, and just for all who experience the pain and loss as a result of avoidable harm and adverse outcomes: the patients, their families, and the staff at the sharp end of error.

“When leaders begin to change their responses to mistakes and failure, asking *what* happened instead of *who* made the error, the culture within health care institutions will begin to change”

Institute for Healthcare Improvement, Leadership Guide to Patient Safety. 2006.

To become safer, health care organisations need to build cultures of quality and safety that are bound in respect and communication, as well as committed to full disclosure, apology, support and resolution for patients and families when harm occurs. How the organisation behaves in such situations is critical to its progress towards creating a safety culture; one of openness and learning. Errors are normal and not necessarily due to poor performance or weakness; the NHS has a large pool of talented and dedicated individuals capable of delivering high quality care but they are frequently let down by the systems they work in.

A number of tools are available to support organisations to better understand and make changes in their safety culture

- *Root cause analysis (RCA):* www.msnpa.nhs.uk/rcatoolkit/course/iindex.htm
- *Being Open:* www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/
- *Foresight Training:* www.npsa.nhs.uk/patientsafety/improvingpatientsafety/humanfactors/foresight/

One way of measuring improvements is through the use of a safety culture/climate survey. Where these are performed, quality and safety culture should be examined from the perspectives of all staff, including clinical and non-clinical staff, as well as members of the Board. Such surveys capture key components of team work, openness, involvement of junior staff and willingness to change.

As part of the pre-work for the campaign it is recommended that all organisations undertake a safety culture/climate assessment survey. Where this is done it should be repeated at the end of the Campaign to determine if there have been any changes in the organisation's culture. Those organisations who wish to use the culture survey as an ongoing improvement tool will need to survey a smaller, representative sample on a more regular basis, such as monthly or quarterly. The results from this could then form part of the Board report – quality dashboard, tracking culture change/improvement over time.

There are a variety of such surveys available and the choice of which to use can be determined locally.

The Manchester Patient Safety Framework can be found at www.npsa.nhs.uk/patientsafety/improvingpatientsafety/humanfactors/mapsaf/

Safety climate survey currently in use with the Safer Patients Initiative can be found at www.uth.tmc.edu/schools/med/imed/patient_safety/survey&tools.htm (registration required).

3. Ensure executive accountability

Chief Executives need to oversee the effective execution of a plan to achieve quality and safety improvement and harm reduction aims, reporting personally to the Board on measurable improvement progress and engaging clinical leadership for the overall campaign.

Specific director accountability should also be allocated for each campaign stream and other leadership interventions as appropriate

This would include all directors – for instance previous campaigns have demonstrated how valuable the involvement of the Finance Director can be. These commitments may be included in the annual personal objective setting process for individual Board members. The Chief Executive would also need to agree with the Chair the contribution that non-executive directors (NEDs) and governors can play in achieving the organisation’s quality and safety improvement aims. The Patient Safety First Campaign are particularly keen to hear how participating Trusts may be involving NEDs and governors in their safety agenda, please share your learning with the Campaign via your organisation’s Campaign contact or directly through our website www.patientsafetyfirst.nhs.uk.

The Chief Executive should ensure that there are clear links between the Campaign and the wider quality, performance management and governance arrangements

The Campaign and related work on safety should be the number one priority. The Campaign has asked Boards to issue a (public) statement to their staff to this effect as part of the ‘sign up’ process. Some suggested text was provided for this purpose should organisations wish to amend and use it (see *Appendix 3* – also available from www.patientsafetyfirst.nhs.uk). The Campaign itself must not be seen as an add-on – or another project – it’s about a change of mindset, about the way we change our behaviour and actions so it becomes ‘the way we do things from here on in’.

4. Establish and monitor explicit system level measures

The mapping and aligning of projects and initiatives already in place suggested in the later section ‘Getting Started’ can help all staff to see the bigger picture. Making clear links as to how the outcomes of all this work aggregate to deliver the highest priority goal – No avoidable harm and no avoidable death – sends a powerful message to the organisation that patient safety is the direction of travel and the most important work done, is that which is going the same way.

Safety scorecard

Boards should be asked to agree and regularly review a small set of system-level measures, based on the best in the UK where possible, as a way to monitor organisation-wide progress. This set of measures will, where possible, form part of an overall dashboard or scorecard of organisational performance alongside, activity and financial performance.

For organisations involved in the Campaign, system-level metrics should include the two measures that require reporting via the Campaign extranet site:

- Hospital Standardised Mortality Ratio (HSMR), which allows Boards to compare their organisation’s risk-adjusted mortality rate to others and to track it within the hospital over time
- Rate of medical harm (expressed per 1,000 patient days. This can be derived from ongoing monitoring using the UK Global Trigger Tool (GTT). This method requires ongoing random review of 20 sets of case notes (of patients discharged in the previous month).

Organisations may also find ‘thematic’ use of the GTT helpful. For example, using the tool to review case notes for 50 anticoagulant therapy patients to identify common triggers and harm events in that service/patient group. Use of the tool in this way does not negate the need for organisation wide case note review. More information on the GTT can be found at:

- www.ihl.org/IHI/Results/WhitePapers/IHIGlobalTriggerToolWhitePaper.htm
- The tool can be found at www.institute.nhs.uk/safecare.

It is important that the scorecard integrates critical safety information from across the organisation and thus includes key measures from risk and governance. Information on incidents, near misses, claims and complaints gives the broader picture of patient safety: measuring harm events using the GTT is only one way of tracking progress and enriching the picture.

In addition the Board should monitor more specific metrics related to the individual Campaign interventions that their organisation is involved in. Finally the organisation may want to add specific locally agreed measures.

An initial audit of harm

In the first instance the Board could commission a review of the notes of the last 50 consecutive deaths in their organisation using a matrix tool based on the reason for admission and the site the patient was initially admitted to. The results of this would then need to be presented back to the Board. The tool is designed to be used as part of a programme for reducing mortality and improving end of life care and helps organisations to drill down into the detail of the studied cases with the intention of identifying system failures. Using it in the early stages of the Campaign work can reveal a host of system defects that were previously unknown at Board level.

The tool and guide can be downloaded from www.institute.nhs.uk/images/documents/BuildingCapability/use_of_3x2_matrix_v1.pdf.

5. Monitor progress and drive execution of plans

Boards can monitor progress more effectively when they receive meaningful safety data and information (as outlined within ‘Safety scorecard’, action number four) in a format that is easy to interpret. This also enables them to quickly hone in on issues impeding progress.

The leadership of the organisation should ensure a project plan for each of the interventions with clear milestones. There should be appropriate and timely reporting of progress against the plan with clear actions with accountability.

Ask hard questions, including:

- Are we on track to achieve the aim? If not, why not?
- What is the improvement strategy? What are key steps planned toward full-scale execution?

6. Build patient safety and improvement knowledge and capability

The Board should be fully conversant with the aims of the Campaign and the role that they can play in ensuring its success. To achieve this, the Board need to determine their own learning needs, such as the need to understand improvement methodologies to fully engage with and challenge any reports it receives. Learning on patient safety and harm reduction should start with the Board and a planned learning programme can help to set an expectation of training and education for all staff. Modules for Board education should answer the questions:

- What is the Board's responsibility and accountability for quality and safety?
- What is the current state of quality improvement and safety in health care overall, in your community, and in your health care organisations? How does prevailing practice stand up to best practice?
- How can Board members effectively leverage their roles and experiences to affect the pace of quality improvement in their organisation?
- What are the best strategies to sustain the gain and drive continuous improvement?

When Boards develop an acute awareness of the role that human factors play in cases of error and harm and have the ability to link this knowledge with an understanding of how to design reliable systems, it can not only alert them to what they see in their own organisation but change how they respond to its failures.

Most Boards and leaders overestimate the front-line staff's ability to improve. In such cases, even with sufficient will and great ideas that have worked elsewhere, execution stalls. Boards can work to ensure that all clinicians, and all staff know how to make performance changes, and leaders are able to help diffuse the new performance levels reliably across the entire system and to hold the gains over time. To achieve this, Boards would need to ensure there is a programme of training in improvement tools and techniques that can be accessed appropriately by all relevant staff.

Getting Started

Prior to testing and implementation of 'Leadership for Safety', organisations may wish to consider the following to move their organisation forward:

- Distribute the How to Guide to the Board and senior leaders in your organisation immediately
- Put the Patient Safety First Campaign on the agendas of the next meetings of the Board and its relevant subcommittees, along with those of the executive leadership and the Medical Executive Committee
- Open these meetings with a short narrative of an actual patient event, illustrating a type or pattern of harm that occurred within the last month in your organisation. This is most effective when connected to your organisation's harm reduction strategy, including lessons learned from the event and specific actions being asked of the Board
- Present the Six Actions to Improve Quality and Reduce Harm, and develop an action plan to move forward on each item within the next month
- Place your organisation's system-level harm metrics on the Board and senior leadership dashboards
- Map out all the activities, projects and initiatives already underway in your organisation. Link these to your system level metrics so that you and all staff can see how the outcomes of this work can aggregate to deliver the higher level goals.

Other Useful Materials and Links

Additional Resources: Governance and Leadership of Quality

Bader B. Best Practices for Board Quality Committees. Great Boards. Accessed April 20, 2006. Available at www.greatbrds.org/newsletter/reprints/Board_quality_committees_best_practices.pdf.

Bader B. 7 Things Your Board Can Do to Improve Quality and Patient Safety. Great Boards. Spring 2006. Available at www.greatboards.org/newsletter/reprints/GBspring06-reprint-quality.pdf.

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Bader B. The right stuff, the right way: 10 ways to improve board meetings. Great Boards. Winter 2005. Available at www.greatboards.org/newsletter/reprints/Ten_Ways_to_Improve_Board_Meetings.pdf.

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National Patient Safety Agency. Seven Steps to Patient Safety (all versions): www.npsa.nhs.uk/patientsafety/improvingpatientsafety/patient-safety-tools-and-guidance/7steps/.

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Vincent C. 'Patient Safety'; 2006 Elsevier, Oxford.

Whittington J, Simmonds T, Jacobsen D. Reducing Hospital Mortality Rates (Part 2). IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2005.

Governance Institute Publications

Board Quality Committees: The Governance Institute's Fax Poll Results. Dec 2002.

Getting on Board with Quality. Board Room Press. February, 2005.

Taking a Strong Stance on Quality Oversight. Board Room Press. October, 2006.

The Board's Role in Quality Oversight: Not a Responsibility That Can Be Delegated. Board Room Press. October, 2004.

Total Quality Management: A Committee Takes the Reins. Board Room Press. April, 2006.

IHI National Forum Presentations

Bader B, Joshi M. Hospital Boards: No Pain, No Gain. IHI National Forum, Dec. 2005. Accessed April 20, 2006. www.delmarvafoundation.org/html/content_pages/presentations/Maulik/ihidecember2005.pdf.

Bader B. Follow the Leaders. IHI National Forum, Dec. 2005. Accessed May 14, 2007. www.ihl.org/ihl/files/Forum/2006/Handouts/C9_BBader_Follow_the_Leaders_Handout.pdf.

Joshi M, Christian D. How Governance Makes a Difference in the Quality of a Hospital's Performance. IHI National Forum, Dec. 2004. Accessed Apr 20, 2006.

www.delmarvafoundation.org/html/content_pages/presentations/Maulik/forihi11_27_2005newbackground.pdf.

Publications from the AHA Center for Healthcare Governance

(To order copies, call 888-540-6111 or e-mail bladewski@americangovernance.com.)

Does Excellent Health Care Governance Lead to Excellent Performance? (Or, can a Great Board make a Difference?).

Hospital Patient Safety and Quality Monitoring: A Resource for Governing Boards and Trustees.

Patient Safety and Quality Reporting for Governance: Data Reporting Guide for Hospital Staff.

Major Associations in Governance Leadership

Center for Healthcare Governance www.americangovernance.com/.

CMS www.cms.hhs.gov/.

Estes Park Institute www.estespark.org/.

Great Boards www.greatboards.org/.

JCAHO: www.jointcommission.org/.

National Center for Healthcare Leadership www.nchl.org/.

National Quality Forum www.qualityforum.org/.

The Governance Institute www.governanceinstitute.com/.

Appendices

Appendix 1

Plan, Do, Study, Act (PDSA) cycle – Carry out an In-Depth Case Study

The CEO, with the assistance of the Medical Director and Director of Nursing, should conduct a detailed, personal investigation of a significant patient injury in the hospital.

- Identify a patient
- Investigate the incident in detail. This includes interviewing the involved patient, family, and staff. The purpose is to understand in great depth the ‘story,’ in all of its complexity, to illuminate the nature and sources of hazard in a complex health care organisation
- The CEO should personally present that case to the Board in a session of no less than one hour in length
- If possible and desirable, the affected patient and/or family should be there at the Board meeting to add their accounts and view in person
- The CEO should review the experience by gaining feedback from the Board and the patient and/or family
- Based on the experience and feedback, make a plan for how you might change the process next time. For example, if the patient found it difficult being questioned in the Board room, work with the patient to find a way to make this experience less uncomfortable. Maybe the way questions are submitted or the venue needs to change.

Appendix 2

Plan, Do, Study, Act (PDSA) cycle – Executive safety walkround

- Identify an area to visit
- Decide your team
- Plan how you will structure the visit. What will the process be?
- Give staff in the area adequate notice and information about the purpose of the walkround
- Do the walkround
- Review the experience with the walkround team and the unit staff
- Based on the experience and feedback, make a plan for how you might change the process next time. For example, if the staff found it difficult to be open and honest about safety issues with a senior executive, work with them to find a way to overcome the issues relating to hierarchy. Maybe the information given to staff before future visits should be more explicit about the focus on improvement rather than judgement
- Remember to check back later that your process for recording and following up actions is working as it should. Refine as necessary.

Appendix 3

Suggested text for safety pledge to staff from the Chief Executive

Patient Safety First Campaign

Guideline paragraph for staff pledge

The paragraph below is intended as a guide, to be issued to staff in whatever form the organisation wishes, as part of its commitment to the campaign cause.

The Patient Safety First Campaign for England begins this Summer. The Campaign 'cause' is 'to make the safety of patients everyone's highest priority', with the aim of achieving 'no avoidable death, and no avoidable harm' across the NHS in England.

The Board have joined the Patient Safety First Campaign for England and confirms to staff that it regards the safety of patients as the highest priority. Whilst it is still important to meet national targets and to remain in financial balance, this must not be achieved at the expense of the safety of our patients. It is important that staff raise issues with their manager or director if they feel that the safety of patients is being compromised.