Can Healthcare Boards Really Make a Difference in Quality and Safety?

Don Carlow

Abstract
There is now a heightened interest on the part of many Canadian healthcare boards in improving processes for assuring quality and safety. This interest has been driven by a number of reports and studies which have identified significant quality and safety issues and the need for greater attention to these by those who lead, including governing boards. Despite progress by some boards, there are those who continue to struggle with their role and how it should be fulfilled. This article addresses why, above all else, quality and safety require greater board attention, precisely what boards should do to fulfill their role and how they should organize themselves to achieve it. Special emphasis is placed on how the boards’ role in quality and safety, if properly fulfilled, can and will have a beneficial impact on outcomes.

Boards and board members throughout the Canadian healthcare system are showing an increasing interest in quality and safety, areas that are becoming a high priority. There has also been a flurry of activity in these fields, with various patient safety organizations emerging, provincial councils or networks being established, research activity on aspects of quality and safety increasing and a variety of multi-institutional collaboratives being undertaken. Some healthcare organizations have moved into a variety of quality improvement (QI) projects and have focused greater attention on patient safety.

While these are encouraging developments for boards, real progress is slow. Some are struggling with exactly how to respond to the many imperatives driving greater attention in these areas, and some are questioning whether all the activity is really productive. Within these developments, there are varying levels of board engagement; some boards are attempting to better define their leadership role for quality and safety, whereas others are continuing to devote most of their energy to finance and other broad areas of governance, which may or may not include passively dabling in narrow-focused, management-driven quality and safety reports, some network-based collaboratives or activities generated by crises or other external influences. In short, quality and safety are not strategically addressed. Adherence to old practices, excessive time on finance, passive receipt of management reports and participation in collaboratives and accreditation — although interesting, these activities are not likely to have a fundamental influence on the organization.

Many boards are asking what it is that they need to do to move their organizations forward, fully realizing that leadership by boards is key to quality improvement and safety. Some have heard of a few organizations that have pursued a broad-based and systematic approach to quality and safety leading to sustained improvement in outcomes. Some have experienced industrial-
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It is well established that leadership is key to success in quality improvement and safety. Organizations that have addressed quality well have done so as a consequence of committed and engaged leadership with enabling cultures and clear direction. Most articles discuss the leadership required from a chief executive officer (CEO) and senior management team, but no less is needed from a board. Frankly, if boards could not make a difference in quality and safety, one would have to seriously question the need for their existence.

What does the evidence tell us about the impact of board involvement? Unfortunately, documented research-based evidence of board effectiveness is sparse. However, there are some findings that reinforce that boards can have a significant impact provided they do certain things and devote sufficient time to quality and safety. It has been reported by the Institute for Healthcare Improvement (IOM) publication *To Err Is Human* (Kohn et al. 2000), the Canadian Adverse Events Study (Baker et al. 2004) and others, including reports in Canada. These publications show significant error rates as well as unexplained and significant variations in practice. McGlynn et al. (2003) reported that American physicians “got it right” 55% of the time – revealing the ever-widening gap between what is known to be recommended care and what is delivered. While no similar study has been conducted in Canada, there are some data that indicate a comparable problem. Yes, there have been some excellent pockets of effort in chronic disease management, but a more coherent approach to closing the gap between what is known and what is practised is needed. In addition fatal medication errors, challenges in infection control and errors/discrepancies in diagnostic medicine contributing to patient harm frequent the daily news.

As examples of issues in medical peer review, diagnostic errors in laboratory medicine and radiology have been serious concerns of late in several Canadian provinces. Based on error rates reported in the literature, these occurrences are not surprising. Many are aware that the industrial Six Sigma standard is 3.4 defects per million. Industry average is about four sigma or 6,210 defects per million. Based on the reported literature, there are 60,000–100,000 defects per million in some diagnostic services. There are those who would argue that these services are not of the nature of a production line, that we must recognize the human factor in making diagnostic assessments, that some “defects” represent a difference of opinion and that a large number of errors/discrepancies do not contribute to patient harm. They may be partly right; however, this issue begs further examination, particularly since several commissions...
and reviews in Canada have concluded that medical peer review and accountability have been notably absent (Cameron 2009; Creaghan 2008; Goudge 2008). It would be interesting to know how many boards nationally actually know their current level of performance in diagnostic medicine. Are error rates in pathology and radiology ever reported to them? Is medical peer review actually taking place in these disciplines? Is it taking place in other medical disciplines?

**Slow Progress and Aiming Low**

Many of the results of the aforementioned studies have been known for a decade or more. While some progress is being made, the slow rate of change is a concern to many. The movement of new developments into practice can take as long as a decade, and the life of many QI projects can go on forever. In many instances, rapid-cycle change does not characterize what is done. Of concern as well is a tendency in Canada to aim low. It would seem that we are often content with achieving levels of performance comparable to an average of other Canadian institutions rather than establishing aggressive stretch targets or comparing ourselves to best-practice institutions. Boards should not set targets or time frames in isolation from management, but neither should they leave it to management to decide the rate or the level of improvement to be achieved.

**Closing the Gap between Knowledge and Practice**

There is a considerable body of literature that supports the notion that care delivered that is consistent with research-based evidence leads to better outcomes as measured by mortality and morbidity. At the same time, there is an ever-increasing complexity of care in association with a large volume of new developments generated by research. It is a huge challenge for physicians and other health professionals to keep abreast of these developments – which may account, in part, for the previously mentioned slow rate of change and gap. As a result, some leading organizations have developed organized systems for synthesizing evidence, developing standards and practice guidelines as well as clinical management tools to facilitate adoption and consistent application in delivering care to patients. Coupled with this, some organizations have developed integrated service-delivery networks with a stronger level of engagement of physicians. The results have been better outcomes for patients at lower costs. These mechanisms have provided the necessary tools for front-line caregivers to deliver quality and safety more consistently. There has also been movement toward providing performance data to front-line caregivers to enable them to continuously improve quality. This has also been strengthened through an interdisciplinary team-based collaborative approach to decision-making.

These steps represent major organizational policy decisions. But to what extent are boards familiar with evidence-based care? Are they familiar with how the organization synthesizes evidence and applies it to the care of patients? Do they understand the relationship between evidence-based care and medical peer review? Do they know the relationship between evidence-based care and other aspects of quality and safety? These are important questions that boards should be addressing.

**Importance of Evidence-Based Care to Quality and Safety**

Many organizations and boards treat evidence-based care, quality and safety separately or in isolation from each other. In fact, some are content to simply address safety alone. But does this isolated approach actually achieve safety or sustained improvement? For example, would it be safe for the wrong drug (not evidence based) to be given but in a manner that represents safe medication practice – right dose, right route, right time? The answer is a resounding no because the outcome for the patient would be compromised. At a recent conference, a senior health official proudly said that in his province the rate of hospital-acquired wound infections for patients with type 2 diabetes undergoing amputation was comparable to or slightly better than the national average. So, is this safe care? Probably not when you consider the Danish study reported by Gaede et al. (2003) that showed that when patients with type 2 diabetes received evidence-based care, the complication rate (strokes, vascular disease, amputations, cardiac complications etc.) was 50% less than in those who received non-evidence-based care. At the time of the health official’s comment, the level of evidence-based care for type 2 diabetes in the concerned province was 42%. Hence, 25% of those who received an amputation might have avoided it if they had received evidence-based care. These patients not only underwent unnecessary surgery, they were exposed to the risk of a hospital-acquired infection.

Consider a fragmented non-standardized approach to trauma care within a region, with each component using differing processes and suboptimal management of the transition from one facility to another. Is this arrangement likely to provide for safe, error-free care? The success of regionally led and coordinated trauma programs emphasizes the impact of organizational design on safety.

For many years, hospitals have been attempting to address incidents such as falls and aspiration. The use of evidence-based approaches to interdisciplinary care for stroke patients has led to breakthrough improvements in these incidents in some facilities.

Evidence-based care is also inextricably linked to quality improvement since the latter is dependent on evidence-driven standards. Boards must ask themselves if they have developed a system-wide approach that is characterized by an integration of evidence-based care, quality improvement and safety.

**Medical Peer Review**

Movement forward with evidence-based care also helps boards
address another perennial issue – medical peer review. In fact, an organized approach to evidence-based care provides the tools to deliver a high standard of care consistently as well as information showing the level of performance contemporaneously, enabling real-time front-line assessments and the implementation of changes where needed. Properly done, it also creates an opportunity for the development of effective clinical governance – and possibly helps to address the continuing suboptimal performance of many medical advisory committees.

An assumption is sometimes made by boards that somewhere, somehow medical peer review is actually taking place and that the annual reappointment of physicians is based on careful assessment of performance. This is despite the fact that boards receive very little in the way of visible evidence of this activity. They should not assume that traditional methods of peer review are actually taking place – methods such as morbidity and mortality conferences, verification of reasonable autopsy rates, analysis of malpractice claims, medical error reporting systems, retrospective chart reviews, observation of care and clinical surveillance. Many such activities used to occur in some hospitals prior to regionalization – but much of this activity has been lost. Its utility may be questioned when you consider low case numbers, hindsight bias, under-reporting, the absence of standardization, a lack of specificity, weak linkages to other organizational activities and a lack of transparency. Many of the shortcomings, however, result from insufficient data and system support along with poorly developed clinical governance and accountability mechanisms.

Frankly, given good information and support, physicians will do the right thing. So evidence-based care provides the opportunity for a whole new era in medical peer review, provided that there are effective mechanisms in place for clinical governance and that research-based evidence is converted into practical, usable tools and information as reported by Straus and Haynes (2009).

Clinical Governance

Clinical governance refers to structures, systems and processes to monitor and improve quality of care. In short, it provides a framework for clinical accountability. It speaks to how clinical services and programs should be organized, usually through programs and distributed networks for the delivery of evidence-based care. Critical to success is the engagement of physicians, with clear definitions of roles, responsibilities and accountabilities for those who lead and for all team members. Also important are an overall clinical governance structure, infrastructure support for synthesis of evidence and the development of clinical management tools. Such arrangements should also be clearly linked to the analysis of new research developments – enabling the achievement of a research-to-standards-to-practice continuum. Many physicians are interested in being connected with board activity, providing a clear opportunity for progress in clinical governance, and without which evidence-based care will not flourish and no effort in quality or safety will be complete.

Quality and Costs

Quality and costs are important considerations. There is a view held that good quality costs more, and that high-quality care and lower costs are contradictory ideas. But the cost of poor-quality care has been the subject of considerable analysis, and methods to assess it have been developed in the United States, as reported by the Agency for Healthcare Research and Quality (2008), where, admittedly, the costs of care are higher and the imperative is hence greater than in Canada. Using a multilevel systematic approach, costs at the population, episode and patient care levels were assessed. Also pursued were evidence-based targeted areas or key processes where there is a high likelihood of waste. The results indicated that poor-quality care increases costs by up to 50%. Similar comprehensive assessments have not been undertaken in Canada; however, analyses of single programs such as cancer and cardiac services have revealed opportunities that could be applied on a larger scale. Some efforts in the application of Lean design techniques to some diagnostic services show early promise. Industry has clearly demonstrated how high quality reduces cost. We should not assume that the same would not apply to healthcare.

Canada has not been exempt from significant quality and safety issues, which no doubt impact on costs. Healthcare boards in Canada are constantly faced with cost pressures and use various top-down strategies to address these challenges, such as program and service cuts, contracted services, across-the-board budget reductions, revenue-generating schemes and other selected initiatives. But as part of cost containment and reduction strategies, boards need to ask how well their processes are working and consider, for example, whether they have (1) evaluated their own costs of poor-quality care using some of the methods recently developed, (2) selected key processes or safety issues for cost assessment and remedial activity, (3) identified areas of non-value-added activity or eliminated areas of clinical activity that are known to be ineffective, (4) compared their performance to that of best-practice organizations such as Intermountain Health and the Mayo Clinic and (5) promoted or investigated the use of industrial techniques to improve processes and reduce waste, such as Lean design techniques. Frankly, the sustainability of healthcare is dependent on boards addressing the costs of poor-quality care in a coherent manner.

Chronic Diseases

The rising prevalence of chronic diseases is a major driver of the need for improved processes and greater attention from governing boards. It is clear that medical advances have led to longer survival, with its consequent impact of chronic diseases
on both the long-term and acute care sectors. Where evidence-based care has been consistently given to patients with chronic disease, research has shown not only improved care but a reduced impact on both of these sectors. Attention to chronic disease management affects not only quality but also sustainability, but I suspect that many boards are unaware of their organization’s performance or strategy in this area.

Fragmentation
While it is clear that some progress is being made, many efforts in quality improvement and safety are fragmented and isolated. Healthcare is characterized by complex systems, within which there are a large number of work and care-delivery processes. An isolated and piecemeal approach leads to disjointed and often unfocused efforts, resulting in the processes not being clearly defined and contributing to waste and not fully effective improvement efforts. Poorly designed processes significantly impact on the appropriate use of professional resources and make the identification of future capacity requirements a serious planning challenge. At the institutional level, this is a major challenge; and for those boards that govern a geographical network of services, the challenge is even greater as they attempt to deal with differing multi-site processes. Boards should be sure to request information about how processes are designed and how well they are working.

What Should Boards Do?
It is clear that things can be better and that boards can and do make a difference, provided they do the right things and spend sufficient time working to improve quality and safety. There are a number of interrelated areas, appropriate to the governance level, in which boards should be involved and that serve to ensure a systematic approach. These areas are outlined in the section below.

Establishing Principles and Values: A Cultural Foundation
An organization’s board has a major role to play in creating a culture that enables quality and safety to flourish. The culture must set the tone by establishing principles and values that will guide the organization. Culture alone, without a plan, will not lead to success, and neither will a plan without a strong cultural foundation. There are a number of principles and values that are conducive to success in quality and safety: a strong and relentless improvement mindset; participative decision-making; data-driven evidence-based decision-making; patient-centred care; an outcome focus; openness and transparency; fairness; interdisciplinary practice; acceptance of professional responsibility; the ability to challenge each other without fear of reprisal; non-punitive reporting of adverse outcomes; system-wide and systematic change.

A board must lead by example and be characterized by these principles and values. Consider these questions:

• If the board expects the organization to be systematic, is the board itself systematic in what it does in quality and safety?
• Is the commitment of the board visible, transparent and well known to the organization?
• Are board decisions evidence based and data driven?
• Does the board continuously improve on what it does?
• Does the board regularly review its own performance in improving health outcomes?
• Does the board devote sufficient time and resources to quality and safety?

There are two other key areas in which the board can have a major influence: (1) insisting on adherence to the principle that those who provide direct care and service to patients should be well supported with systems and processes that enable them through interdisciplinary practice to deliver quality, to assess performance and to directly influence outcomes; and (2) being adamant that patients be informed and involved in decisions about their care. The notion is that the quality will be better and costs will be less.

Quality Plan and Priorities
The importance of a well-developed plan for quality and safety cannot be overstated. A system-wide plan must be developed that provides the framework for the total organizational effort, as opposed to just looking at management reports, selected indicators or information about selected QI projects or collaboratives. While the board will delegate to management the responsibility to develop the plan, it must provide clear direction on what it expects:

• There should be a clear vision for quality and safety that expresses how the organization wishes to position itself, how it aspires to deliver quality service and its commitment to improving health outcomes.
• The plan should be organization wide and should integrate evidence-based care, quality and safety into a coherent whole.
• The plan should be multi-level, with elements that define plans for population health needs and broad cross-cutting organization-wide initiatives, as well as specific programs and networks.
• The plan should identify key process areas that have a high likelihood to improve quality and reduce waste.
• Recognizing the time it takes to address longer-term aspects of improvement, the board should expect the identification of “quick wins.”
• The plan should define clear priorities, identifying where the organization should put its efforts to achieve the greatest impact in improving health outcomes.
• Measurable targets should be identified that are aggressive and aspire to meet or exceed best practices.
• Response times for the achievement of targets should be based on accepted principles of rapid-cycle improvement.

A board may decide to focus on a few areas such as safety, access and appropriateness as a start. Or it may want to give special attention to a medication safety plan, an infection control plan and evidence-based care plan or an incident reporting system. But in doing so, it must think organization wide. For example, in examining wait times, it should address the total wait from a patient’s perspective and the point of entry into care. It should not limit its view of infection control to one or two facilities. It cannot just examine coordination of care within a facility, but must assess coordination and integration across the system. It must focus not just on service delivery but also on population health status and interventions that are within its ability to influence.

The board must also recognize that a few organization-wide initiatives will not capture and address all aspects of quality and safety. Healthcare organizations are a collection of heterogeneous programs and services that differ sufficiently to require specific plans that will be viewed and monitored by the board. This includes programs for cancer, heart disease, stroke, renal disease, maternal and child health, mental illness, Aboriginal health and a variety of chronic diseases.

Building a culture for quality and having a plan will be major driving forces in moving forward with quality and safety.

Quality Improvement System Support
Having a central QI resource to support an organization’s efforts is vital to success in quality and safety. Healthcare organizations have for decades devoted significant resources to support the financial area, but until recently there has been little in the way of resources to support quality and safety. This is changing, but the support is often modest at best. The provision of support recognizes the importance of a knowledgeable central resource for all the organization’s quality and safety efforts. Such a resource can integrate and coordinate research, evidence-based care, quality, safety and performance reporting within a unified portfolio. It can coordinate the development and implementation of the quality and safety plan and develop policies to guide the entire organization. It serves to support teams with methods and tools as well as the facilitation of group activities. It can also coordinate educational and developmental needs and identify best practices and QI projects, while keeping an inventory of such. Its role in research synthesis provides the basis for the development of policy, standards, guidelines and clinical management tools. It can also coordinate the organization’s involvement with various provincial initiatives and with the activities of provincial quality networks or councils.

It is a challenge to provide the level of financial support required for such a central resource. With budgetary limitations and no specific funding being provided through ministry resources, progress has been slow in this area, and yet the effectiveness of governance for quality and safety depends a great deal on this resource. The board should require a plan to be developed for the provision of such a central resource and may wish to consider an upfront investment that could deliver future offsetting cost savings while improving quality and safety.

Organizational Design
How an organization is put together has a major influence on its ability to effectively deploy and manage an evidence-based quality and safety strategy. Boards have generally not had a role to play, except to be advised of an organizational design plan or to possibly ratify one or two senior executive appointments reporting to the CEO. Although there are shifts occurring in how healthcare assembles the elements of the organizational puzzle, there continues to be inordinate emphasis on functionally oriented arrangements rather than the clinical components; yet involvement and support of the latter are critical to mission achievement, meeting quality and safety goals as well as achieving a patient-centred approach. Many leading organizations have clearly demonstrated improved outcomes associated with stronger physician engagement and the establishment of geographically distributed programs and networks well supported by a central QI resource driven by research-based evidence. Clinically based programs and networks – each a clinical microsystem – can enable a patient-centred approach as well as the consistent delivery of evidence-based care using clinical management tools. Those at the care-delivery level can be linked to these microsystems and supported in their efforts to deliver quality and safety, monitor their own performance and continue to improve in response to patients’ needs. Such a model also enables the addressing of patient preferences and decisions about their care. It is important that such an organizational arrangement effectively links to primary healthcare as well as initiatives in chronic disease management.

Those who lead the programs and networks can come together, formulating a clinical governance mechanism that, with the support of a central quality resource, better assumes responsibility for quality and safety as well as clinical accountability. Such organizational arrangements can mitigate against isolated and fragmented activities and ensure that safety is embedded in a much broader framework, one that has a greater likelihood of delivering truly safe care. Also of interest to the board should be the design of patient care delivery mechanisms, considering their impact on cost and quality and their role in improving outcomes. Board members should understand the importance of organizational design in achieving quality and safety and should play a role in reviewing and approving such arrangements.
Policy Development and Approval
Previous mention has been made of the board’s role in establishing principles and values to guide the organization, and the importance of a central resource for policy development. The board has an important role to play in reviewing and approving policy and ensuring that it is consistent with its mission, vision and values and that it reinforces and aligns with the culture of quality improvement. Policy areas requiring attention include disclosure, non-punitive reporting, ethical review, informed decision-making, confidentiality, incident reporting, organizational design, team-based care, patients’ rights, performance assessment, compensation, reward systems and how the board will organize and conduct itself in keeping with its role in quality and safety.

System-Wide Monitoring
An important role for the board is to monitor overall system performance relative to quality and safety. It is hard to improve on the IOM framework for monitoring, as described in *To Err Is Human* (Kohn et al. 2000), which includes elements such as safety, effectiveness, patient-centredness, timeliness, efficiency and equity. In addition to organization-wide indicators, important areas for the board to monitor are “dashboard” indicators of service-delivery performance, program-specific indicators, health status indicators, quality and safety plan, values and principles, CEO and senior team performance and the quality improvement system.

Dashboard Indicators of Service-Delivery Performance
The ability of a board to monitor selected dashboard service-delivery indicators is influenced by the organization’s capability to deliver and analyze the required information. Dashboard indicators, using the IOM framework, should provide the board with a broad snapshot of how the organization is functioning and might include a dozen or more categories of organization-wide activity. Service areas to monitor might include safety, infection control results, medication error reporting, selected incidents such as falls or aspiration, critical incidents, mortality ratios, wait times (system-wide) for various diagnostic and treatment procedures, lengths of stay, readmission rates, patient placement, emergency throughput, occupancy rates, etc. Such indicators are usually reviewed at least quarterly. Indicators also need to be reviewed regularly as to their continuing relevance. For each indicator, there should be a clear description of current performance relative to the desired target, a comparison to best practice and action plans to address performance below targets and the achievement of the desired outcome.

Program-Specific Indicators
Healthcare is not homogeneous, and system-wide performance indicators do not tell the whole story. The board should therefore regularly review selected indicators for clinical program and services areas. These might include diagnostic, surgical, cardiac, cancer, renal, stroke, mental health and addiction, maternal and child health, chronic disease management, primary healthcare, long-term care/residential and other services appropriate to the clinical program role of the organization. These can be reviewed on a regular cycle, possibly annually, with three or four indicators to provide the picture and a basis for action.

Health Status Indicators
As boards continue to broaden their responsibilities to include health promotion and disease prevention, the monitoring of selected health status indicators as well as health habits of the population becomes imperative. Clearly, boards do not have governance over all elements that contribute to population health, but an emphasis should be placed on those aspects that are within the organization’s ability to influence. Such indicators are probably best reviewed annually since interventions take much longer to have impact.

Quality and Safety Plan
The board should regularly review progress toward achieving the quality and safety plan, particularly the priorities and targets. Performance should be compared to best practices, and action plans should be created to address any need for improvement. Monitoring should include key processes, major initiatives in process redesign and other streamlining activities directed to quality, improved efficiency and cost reduction. The overall plan should be reviewed and updated annually, including the consideration of how well the board is performing in achieving the desired health and service outcomes.

Values and Principles
An enabling culture underpins success in quality and safety efforts. The board should regularly review its own cultural performance, as well as that of the CEO and senior team, and how the cultural values cascade throughout the entire organization. This can be assessed in part through rounded performance review mechanisms as well as staff satisfaction surveys. The results of patient satisfaction surveys can also be a valuable resource in cultural assessment.

CEO and Senior Team Performance
An important role for the board is to establish clear expectations for the CEO and senior team regarding quality and safety and regularly monitor their performance. The board should expect full commitment and leadership from the senior team, and processes, systems and culture should reflect the results of their leadership. The board should support defined educational programs for the CEO and senior team – toward building a
cohesive and aligned senior team who are accountable, who can challenge each other, who can make effective and timely decisions and who live the values and principles enunciated by the board. Without the full commitment of the CEO and senior team, any potential for success will be seriously compromised; and while efforts at quality and safety might still be pursued in parts of the organization, they will be fragmented and non-systematic.

Quality Improvement System
The board should not only review outcomes but also ensure that systems are in place to support quality and safety. It is intriguing the extent to which boards go in assessing the financial integrity of their organization through internal and external audit activities leading to detailed reports regarding accounting standards and financial risks. We should expect the same attention from boards to quality and safety.

Earlier, mention was made of the importance of a central QI resource; such a resource should have processes for reviewing and synthesizing evidence, creating standards and assisting in the organization’s translation into practice through the use of clinical management tools. The board must ensure that these processes are working.

Some may feel that this function is served through accreditation; however, accreditation generally does not provide a level of rigour that can ensure a well-functioning system for quality and safety. There have been provincially led audits undertaken in two Canadian provinces covering areas such as infection control and surgical services, with many attendant recommendations. In addition, there have been several commissions on specific services – more recently, diagnostic – that identify significant quality issues, and these have been done in accredited facilities. However, the evaluation of support systems for quality and safety needs more in-depth attention.

When a board gets involved, it can have a powerful influence on an organization’s performance in quality and safety.

How Should the Board Fulfill Its Role?
There are a number of things the board should do to fulfill its role in quality and safety: clearly define its responsibilities, orient board members, establish a good composition, set up a quality committee and plan a calendar of activities.

Board Responsibility Clearly Defined
The role and responsibility of the board for quality and safety should be clearly set out in organizing documents such as bylaws and board and committee terms of reference. When the board gets involved and the organization is made aware of the board’s interest and activities in the areas of quality and safety, it can have a powerful influence on performance in these areas.

Board Education and Orientation
Board members should be prepared for their roles through a well-structured orientation program. All board members should be expected to participate in an education program on the principles and processes of quality and safety – particularly in relation to governance responsibility. They need to be familiar with the language and be comfortable asking challenging and relevant questions about quality and safety. Such programs are probably best organized so that multiple boards can participate, possibly organized by provincial councils or networks. It would also be useful to have an ongoing inter-board forum where issues and experiences in quality and safety can be shared among multiple boards. There should also be educational updates as part of regular board activities.

Board Composition
The composition of the board should include people with a blend of clinical and quality improvement knowledge along with business leaders who have knowledge of areas such as Six Sigma, Lean production and various QI methods. Such a mix will enrich the board’s discussions considerably. Boards are often composed of those with financial or legal expertise or experience in broad areas of governance. These areas are important but should not dominate the membership of the board.

Quality Committee
Within the overall committee structure of the board, there should be a quality committee that includes members with clinical and quality expertise. The deliberations of the committee will be enhanced through the active involvement of the chief medical and quality officers, who will act as a resource to the committee just a senior finance staff act as a resource to finance and audit committees.

Plan a Calendar of Activities
The quality committee should have a detailed plan for its activities that is encompassed in an annual plan or calendar of activities. This plan is the basis for agenda development; it becomes an accountability framework and outlines clearly how and when the committee and board will fulfill their responsibilities. But while detailed discussions will take place at the committee level, this does not replace in-depth discussions and debate at the board level.

The calendar of activities should include a regular review of values and principles, the quality and safety plan, system/
resource support, enabling policies, organizational design (including clinical governance and program structure), dashboard and program-specific indicators, key processes in the improvement plan, quality/safety project reports, progress with medical peer review, accreditation results, medical legal/risk management reports, special external reviews and a review of how the committee is progressing in fulfilling its role. All reports should be in clear and understandable language and reasonably succinct. Where possible, they should be prepared in a predetermined template format, focus on a few critical indicators of performance that are unique to the areas under consideration and be consistent with board-established priorities. The committee should expect targets to be aggressive and completed within well-defined (and, where possible, short) time frames. During committee-level discussions, it is important that clinical program, service delivery and network leaders be present and actively engaged in the dialogue. The expectations of the board and committee should be known throughout the organization.

**Conclusion**

It is clear that boards have an important role to play in leading quality improvement and safety. Properly fulfilled, the result will be a beneficial impact on outcomes. While some boards continue to struggle, others are showing signs of significant progress. This article has addressed why a board’s involvement is important, what things the board should do and how the board should organize itself to fulfill this role. The importance of a systematic and strategic approach supported by a culture of quality, the provision of adequate support resources, stronger clinical engagement, a well prepared and appropriately structured board devoting a large percentage of its time to quality and safety have been emphasized. Hopefully, the movement toward enhanced roles for boards will continue and the days of isolated and fragmented efforts are numbered. A higher level of engagement by ministries of health, of various provincial quality and safety councils, a greater level of sharing among boards and the activities of other quality and patient safety organizations will be helpful.

**References**


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