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Non-Executive Directors and Mortality Assurance in the NHS – Are they Fit for Purpose?

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Abstract

In UK NHS organizations, Non-Executives on Boards of Directors play a critical role in ensuring that organizations are delivering safe patient care. The role of Non-Executive Directors (NEDs) is to 'challenge the decisions of the Board and help develop proposals on priorities, risk mitigation, values, standards and strategy'. This paper examines the extent to which they are able to do this in areas where the assessment of risk and its mitigation requires highly technical medical knowledge. Specifically, whether the highly technical nature of trust mortality data represents an obstacle to the proper and effective functioning of the Non-Executive Directors and their ability to question and hold operational directors to account for poor performance. This work is pertinent in light of recent high profile failures in corporate governance, where abnormal mortality statistics (and other important indicators of poor patient safety) have not triggered an appropriate Board response or corresponding remedial action. Using a mixed methods approach generating both qualitative (interview) and quantitative (survey) data this paper provides an assessment of NEDs' knowledge and capabilities in the area of mortality assurance. The findings show that with the exception of those that are clinically trained, NEDs feel that they are unable to properly scrutinize trust mortality rates and hold the Board to account for the suitability and appropriateness of responses. They perceived themselves to be heavily reliant on the integrity of the Medical Director and to be unable to provide independent assurance in this area. These findings suggest the need for additional specialized training for Non-Executive Directors in order for them to properly and fully undertake their roles.

'Non-Executive Directors should satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management and governance are robust and implemented.'

Keywords: Non-executive directors; Mortality assurance; Mortality ratio

In UK NHS organizations, the Non-Executive Directors (NEDs) play a crucial role in ensuring that organizations are delivering safe patient care. The role of NEDs is to 'challenge the decisions of the Board and help develop proposals on priorities, risk mitigation, values, standards and strategy'. This paper sets out the findings of a study that examined the extent to which NEDs are able to do this in areas where the assessment of risk and its mitigation requires highly technical knowledge, with particular reference to hospital mortality.

Focusing specifically on the area of mortality assurance, this paper sets out to determine:

1. Whether NEDs perceive themselves as capable of challenging their Executive colleagues on mortality data and on planned interventions to improve.
2. The development needs for NEDs, to enable them to effectively challenge their Executive colleagues in highly technical areas or areas in which they are non-specialists.

Introduction

Particularly in the NHS (as with many healthcare organizations across the world), NEDs are drawn from a diverse knowledge and experience base [1]. The majorities are non-clinical, and join the NHS from the private sector or from non-health areas of the public sector. As a result many NEDs are likely to lack the technical capability (and possibly also the confidence) to effectively challenge their Executive colleagues [2,3]. This is likely to be particularly pronounced in the areas of clinical quality and effectiveness. These issues are also likely to be compounded by the significant time constraints that are placed on NEDs, who actually spend far less time than their Executive colleagues do in the organization, have limited access to information and have comparatively little support infrastructure.

Achieving excellence in areas such as mortality assurance requires a degree of technical knowledge that may be more challenging to meet for NEDs with business backgrounds. Goeschel et al. [4], Bevington [5] proposed that these issues might be mitigated by a package of measures that included continuous education on quality and patient safety standards, as well as expected outcomes, with the aim of improving 'Boards quality literacy'. In particular, the use of collaborative workshops was advocated [4] as was giving the clinical Executive Directors (Medical and Nursing Directors) the opportunity to work with NEDs to improve the level and quality of their enquiry. By building a strong relationship between the NEDs and clinical leaders, it was thought that both groups could work together to develop a mutual understanding of the challenges associated with delivering, measuring and assuring high quality care.

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It is also noted that the effectiveness of the Boards could be enhanced through the greater involvement of clinicians on Boards. Their increased presence would help Boards to more effectively perform their function. In this regard, recent research indicates a performance advantage for hospital Boards with high physician membership [6]. Certainly, previous studies i.e. Joshi and Hines have found a relationship between high levels of Board engagement in quality and risk adjusted hospital mortality rates [7].

Methods

The project was undertaken using a mixed methods approach. An initial qualitative component comprising in-depth semi-structured interviews was carried out with 6 NEDs of an NHS organization. These focused on NEDs' understanding of Hospital Standardized Mortality Ratios (HSMR) and their confidence to 'challenge and hold to account' the Executive team in relation to hospital mortality. Secondly, a national postal survey of Acute Trust NEDs (based on the same questions)was carried out. In total, packs of 6 surveys (one for each NED) were sent to 169 NHS organizations in England. These generated 99 survey responses, which were coded and analyzed by theme.

Findings

The interview and survey data showed that NEDs have a developing understanding of mortality. Those that were questioned directly appeared to understand the systems for mortality assurance in their organization. These findings were supported by the survey, which showed that, as might be expected, NEDs' perception of the HSMR for their Trust was strongly correlated with their self-reported Trust HSMR (Chi-Square 67.189, p-value 1.54e-12). However it was noteworthy that 2 NEDs reporting HSMR <90 and 2 >110 perceived their performance as 'average' indicating a lack of in-depth understanding of the metric.

In line with the wider national context, when asked 'Do we know why our patients die?' most believed that more could be done. Most were keen to obtain more understandable comparative information and did not appear to always have confidence in the range of internal and external reporting tools used to provide assurance in the area of mortality. Their confidence in the information being sufficient for identifying one off or systemic failures was significantly lower (mean 6.75 (1.78; p=0.0021, paired T test)) than their perceived ability to use the information in practice to scrutinize mortality and strategy (mean 7.18 (1.49)) and to challenge the Executive Team (mean 7.59 (1.68; p = 2.38E-06)).

Across both the interview and survey data, many described a gap in information provision or access, difficulties in interpreting results or reports, and having sufficient time to understand the reports. There was a strong awareness of there being an information asymmetry between NEDs and the Executive Directors. 9 NEDs did not feel that the data they had enabled them to scrutinize and confidently challenge issues relating to patient care, while 72 used the data to challenge regularly at board level, 23 occasionally and only 4 never.

In relation to the information needs of NEDs, 15 NEDs identified a requirement for greater depth of specialty specific information to enable benchmarking, 9 identified a need for support with understanding or interpretation of. Several (survey) comments were insightful in this regard. One comment indicated an understanding of the need to develop a cogent story enabling a focus more on challenge around necessary actions.

'Not so much more information but rather development in interpretation and understanding a) context plus b) implications - the 'so what' questions.'

Two comments highlighted potential limitations and reliance on openness of access to information / information asymmetry;

'Complete transparency over trend data from senior Executive Team and at the earliest possible time, if they suspect something might be amiss'

'Just a need to continually question Execs at every Board meeting'

Another indicated limitations in personal capability and the role of the medical NED, as another dimension of information asymmetry.

'As a non-clinical, I depend on the experts for assurance.'

In the questions that focused on the NEDs' perceived need for personal development in the area of mortality, 73 identified some areas for development, 13 indicated a broad range of development needs and only 1 recognized a very significant development need. 9 NEDs (8 non-medical/business, 1 health and social care background) felt no need for personal development in this area. 89 /98 NEDs recognized their need for development by broadening their exposure and understanding through sitting on audit, clinical governance and/or risk management committees.

Discussion

This work is pertinent in the light of recent high profile failures in corporate governance, where abnormal mortality statistics (and other important indicators of poor patient safety) have not triggered an appropriate board response or corresponding remedial action. The data shows that NEDs perceive there to be clear obstacles preventing them from fulfilling this element of their role, primarily because of their own lack of technical expertise, and a lack of support in this area. While clinical colleagues might compensate for a lack of healthcare experience amongst NEDS by supporting their colleagues, there is a clear evidence of a 'blind-spot' that has the potential to impact on Board assurance and, therefore on the quality of care [3,8].

These findings are consistent with studies that show a correlation between Board effectiveness and their engagement in quality and hospital performance [9]. The literature suggests an association between Board engagement in quality and risk adjusted hospital mortality rates [7,8,10-12]. The literature, moreover, indicates that assertive questioning by Board members is associated with clinical content of Board minutes and a tendency for better performance [1].

While it seems unlikely that the knowledge asymmetry between NEDs and their Executive colleagues might be fully resolved, additional training, support and improved clinical representation should form part of a package of measures. In relation to data quality specifically, Bevington [5] notes that, by satisfying themselves in three domains (assessment methods, improvement processes, and evidence for assurance that these are both effective),Board members might improve their effectiveness.

Conclusions

The highly technical nature of mortality data represents an obstacle to the proper and effective functioning of Non-Executive Directors. NEDs were generally doubtful of their ability to properly question and hold Executive Directors to account. Non-clinical NEDs are heavily reliant on clinical NEDs, but specifically on the Medical Director for assurance. To a degree, most are not confident to undertake their own analysis and scrutiny of mortality data and feel unable to evaluate

proposals made by Executive teams to mitigate and manage risk. To mitigate these issues, greater training should be provided to non-clinical NEDs, and organizations should consider the need for sub specialization and the possibility of recruiting more medically qualified NEDs.

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