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Enacting corporate governance of healthcare safety and quality: a dramaturgy of hospital boards in England

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Abstract The governance of patient safety is a challenging concern for all health systems. Yet, while the role of executive boards receives increased scrutiny, the area remains theoretically and methodologically underdeveloped. Specifically, we lack a detailed understanding of the performative aspects at play: what board members say and do to discharge their accountabilities for patient safety. This article draws on qualitative data from overt non-participant observation of four NHS hospital Foundation Trust boards in England. Applying a dramaturgical framework to explore scripting, setting, staging and performance, we found important differences between case study sites in the performative dimensions of processing and interpretation of infection control data. We detail the practices associated with these differences - the legitimation of current performance, the querying of data classification, and the naming and shaming of executives – to consider their implications.

Keywords: governance, National Health Service (NHS), safety

Introduction

Patient safety remains a high-profile health policy issue, traceable internationally since landmark publications in the USA (Institute of Medicine 1999) and UK (Department of Health 2000) highlighted the scale of medical error and harm to patients. Errors were framed as conditioned, precipitated and exacerbated by systemic and latent organisational factors - and thus amenable to prevention (Waring *et al*. 2010). Empirical research informed by organisational psychology located clinical failures within organisational contexts ('clinical micro-systems'), seeing errors as the result of embedded unsafe practices rather than individual failings (Nelson *et al*. 2008). The solution proposed for this framing of the problem was implementation of standardised processes and 'designing out' errors, both at the level of specific interventions and whole-organisation safety systems. While this perspective informs much empirical patient safety research, Lamont and Waring (2015) offer a subtle reading of a tension evident within the literature: is patient safety a 'thing' that may be enhanced through technical solutions; or a more nebulous, contested phenomenon requiring attendance to the socio-cultural context of

proposed changes to practice (Rowley and Waring 2011)? From a socio-cultural perspective, transfer of technical 'solutions' between industries risks subversion by existing professional hierarchies, as observed by Currie *et al*. (2009) in an evaluation of incident reporting techniques developed in the aviation industry and subsequently implemented within a hospital. Crucially, it is feared that embedded social and organisational practices which make technical systems work within their original contexts may be overlooked (Macrae 2014); and that this explains the limited impact of patient safety interventions (Sheldon *et al*. 2004). The implication is that greater attention is required to ambiguities at play, and greater insight into the lived experience of patient safety work requires combination of theory with empirical data.

The failure of the Executive board to ensure safe clinical practice was implicated in events at Mid Staffordshire NHS Trust in the UK (Francis 2013) where many patients received sub-standard care in a context of chaotic management systems. The detailed response to these events is outlined in *A promise to learn – a commitment to act* (Department of Health 2013) which informed development of a National Patient Safety Alert System, publication of 'never events' data, and a Patient Safety Collaboratives programme to support improvements. As entities with statutory responsibilities for oversight, boards have ultimate responsibility for upholding the quality and safety of care delivered within their organisation, and are charged with a fundamental role in the governance of patient safety through defining and managing objectives, strategy, priorities, culture and systems of organisational control (NHS Leadership Academy 2013).

Empirical literature identifies governance practices as potentially important in safeguarding patient safety, including routine feedback and monitoring of statistical data, strategic involvement of clinicians in quality improvement, and attention to external governance systems (Jha and Epstein 2010, Jiang *et al*. 2009, 2011, Vaughn *et al*. 2006). However, as with the broader patient safety research literature above, considerable weaknesses in study design and theoretical orientation remain (Millar *et al*. 2013). While qualitative and case-study research is emerging (Baker *et al*. 2010, Ramsay *et al*. 2010), significant gaps remain in our understanding of the processes of organisation associated with board governance of patient safety in hospital settings (Chambers and Cornforth 2012). Specifically, we lack detailed understanding of what board members do, and the manner in which they do so, as they seek to discharge obligations with regard to patient safety (Millar *et al*. 2013, Nicolini *et al*. 2011, Waring 2007). The concept performativity may prove helpful in exploring board practices (Freeman and Peck 2007, 2010), the purpose of this article being to explore its application empirically.

Below, we introduce performativity and consider its influence within the study of organisational life; trace its foundations to the work of Austin (1962) and Goffman (1974); and note its empirical application in the context of participatory governance (Hajer 2004). We then employ Hajer's framework of scripting, setting, staging and performance to hospital executive board meetings, and explore implications for patient safety governance.

The foundations of performativity: Austin and Goffman

Austin (1962) coined the neologism 'performativity' to describe instances in which the utterance of a phrase constitutes an action which changes reality rather than describes it; a simultaneous 'saying' and 'doing' which requires others to act in accordance with its implications. Austin's paradigmatic case is the phrase 'I do' when spoken within the context of a marriage ceremony; a phrase requiring those exchanging vows to act, and be acted upon by others, as a married couple from that point forward. Austin additionally stipulates that performative utterances are meaningful actions that are neither true nor false but generative, that is, they create a social reality.